Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0414	A. BUILDING: _____ B. WING _____	C 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHMINSTER	8919 PARK ROAD CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS An unannounced licensure survey and complaint investigation was conducted from 10/14/2025 to 10/16/2025. Event ID #NRP211. The following intakes were investigated: NC00214456, NC00210045, NC00209940, NC00220306, NC00214137. 1 of 5 complaint allegations resulted in deficiency.	L 000		
L 052	.2210(D) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (d) A facility shall ensure that the report of investigation is printed or typed and sent to the Division of Health Service Regulation within five working days of the allegation. The report shall include: (1) the date and time of the alleged incident; (2) the patient's full name and room number; (3) details of the allegation and any injury; (4) names of the accused and any witnesses; (5) names of the facility staff who investigated the allegation; (6) results of the investigation; and (7) any corrective action that was taken by the facility. This Rule is not met as evidenced by: Based on record review, and staff and	L 052	P.C Attached Cam Cecil, LNHA Administrator	

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L 052	Continued From page 1 Responsible Party interviews, the facility failed to submit the results of an investigation of an allegation of misappropriation that included the date/time of the alleged incident, the patients full name/room number, details of the allegation, names of accused and any witnesses, name of facility staff who investigated the allegation, results of the investigation, and any corrective action that taken by the facility to the Division of Health Service Regulation (DHSR) within 5 working days of the allegation for 1 of 3 sampled residents reviewed for abuse (Resident #8). Findings included: Review of the facility's investigation documentation revealed the facility's 24-hour initial allegation report was sent to DHSR on 2/28/24 at 4:52 PM via fax transmission. The 24-hour initial report indicated there was an allegation of misappropriation of resident property and the date and time of incident was unknown. The report revealed the allegation was reported to law enforcement on 2/28/24. A review of email correspondence provided by the Administrator on 10/15/25 revealed the Resident Family Life (RFL) Coordinator sent an email to the former Administrator on 3/7/24 at 5:02 PM with an email attachment which included the investigation summary of Resident #8's missing money. The summary was then forwarded from the former Administrator to the Director of Nursing (DON) on 3/7/24 at 5:03 PM. The summary attachment indicated Resident #8 was missing one of three stacks of money in his room and he believed the money had been missing for about "a month, but at least three weeks." The report indicated Resident #8 was confused on several facts pertaining to the missing money, as	L 052		

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L 052	Continued From page 2 Resident #8 initially stated the three stacks of money were located in different areas of his room and then stated the stacks of money were all in one location. The report revealed Resident #8 was surprised when "they" took the stack of money with the least amount of money in it. The investigation summary revealed Resident #8 had the other two stacks of money which he believed to total around $1,800. The summary indicated Resident #8 initially did not know the total amount of money for all three stacks of money, but eventually Resident #8 stated the stacks totaled to a little less than $3,000. The investigation summary also indicated Resident #8's personal care manager deposited the remaining cash in the bank after the alleged incident. The investigation summary revealed facility staff and Resident #8's personal care manager did not know when or where he acquired the money, the total amount of money in Resident #8's room was uncertain, and they did not know how long the money was missing. A review of an email correspondence from Health Care Personnel Investigations to the former Administrator on 3/13/25 revealed a five-day investigation report associated with the 24-hour report submitted on 2/28/24 had not been received by DHSR. The email indicated the facility should fax the 5-day investigation report as soon as possible. The facility could not produce any documentation indicating the 5-day investigation repo t was submitted to DHSR. A telephone interview with Resident #8's Responsible Party (RP) on 10/15/25 at 9:45 AM was conducted. He stated he recalled the incident of missing money and that Resident #8	L 052		

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L 052	Continued From page 3 tended to have a lot of cash in his possession, would misplace items frequently and would get "paranoid" about the missing items. Resident #8's RP stated Resident #8 could be difficult to deal with and did not believe any staff member or visitor took any of Resident #8's belongings or money. He stated the RFL Coordinator informed him of the incident and kept him informed during the investigation process. During an interview on 10/15/25 at 11:10 AM, the RFL Coordinator stated she was familiar with Resident #8 who died this past summer and the alleged misappropriation of money reported in February 2024. She stated Resident #8 had a history of hoarding thousands of dollars in his pants pockets and in his room. The RFL Coordinator stated she spoke to Resident #8 multiple times and asked him to keep his money locked up in his safe in his room, which he refused to do. She stated at the time of this alleged incident, Resident #8 was living in the assisted living unit and had private care managers who used to take him off campus and he would access his money on outings since his family lived out of town. The RFL Coordinator stated Resident #8's private care manager stopped him from acquiring more cash after this incident and eventually when Resident #8 moved to skilled care for increased care needs, he did not have a need to have money in his room. The RFL Coordinator revealed she had been employed at the facility for many years, and she used to be responsible for submit.ing investigation reports to DHSR, but the former Administrator changed the procedure when she was hired at the facility. She stated the former Administrator wanted to submit the investigations to DHSR. The RFL Coordinator stated she would complete the investigation summary, and she	L 052		

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L 052	Continued From page 4 would give the summary to the former Administrator to submit to DHSR. A telephone interview with the former Administrator on 10/15/25 at 11:33 AM revealed she had some recollection of Resident #8 and the alleged misappropriation incident in February 2024. She stated she turned in all 5-day investigation reports on time to include the alleged misappropriation investigation for Resident #8 in March 2024. She stated the procedure was that the RFL Coordinator would complete the investigation summary and then the former Administrator would submit the investigations to DHSR. The Former Administrator did not recall receiving an email from Health Care Personnel Investigation about the 5-day investigation report not being received by DHSR on 3/13/24. An additional interview with the RFL Coordinator on 10/16/25 at 10:39 AM revealed she emailed the investigation summary to the former Administrator for the alleged allegation on 3/7/24 for the former Administrator to send to DHSR. An interview was conducted on 5/15/25 at 11:59 AM with the DON. She stated the former Administrator submitted all the initial and 5-day investigation reports to DHSR. The DON further stated she did not submit any investigations to DHSR and the former Administrator would typically send her a copy of the investigation summaries to keep her informed. An interview with the Administrator on 10/16/25 at 12:19 PM revealed he had the expectation that all investigation reports from the facility would be turned into DHSR within the correct timeline.	L 052		

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L 061	Continued From page 5	L 061		
L 061	.2301(A) PATIENT ASSESSMENT AND CARE PLANNING 10A-13D.2301 (a) At the time each patient is admitted, the facility shall ensure medical orders are available for the patient's immediate care and that, within 24 hours, a nursing assessment of immediate needs is completed by a registered nurse and measures implemented as appropriate. This Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a resident was assessed by a Registered Nurse (RN) within 24 hours of admission for 4 of 5 residents reviewed for resident assessments (Resident #1, Resident #2, Resident #3, and Resident #4). The findings included: a. Resident #4 was admitted to the facility on 10/17/23 with diagnoses including stroke and altered mental status. The admission nursing assessment dated 10/17/23 was completed and signed by Nurse #2 with credentials Licensed Practical Nurse (LPN). b. Resident #1 was admitted to the facility on 10/08/24 with diagnoses including Alzheimer's disease and congestive heart failure. A review of Resident #1's medical record revealed an admission nursing assessment was not completed. c. Resident #2 was admitted to the facility on	L 061		

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L 061	Continued From page 6 10/09/24 with diagnoses including Alzheimer's disease, hypertension and osteoarthritis. Resident #2's admission nursing assessment dated 10/09/24 was completed and signed by Nurse #3 with credentials LPN. d. Resident #3 was admitted to the facility on 8/22/25 with diagnoses including congestive heart failure, atrial fibrillation and stage 3 chronic kidney disease. Resident #3's admission nursing assessment dated 8/22/25 was completed and signed by Nurse #1 with credentials LPN. During an interview conducted with Nurse #2 on 10/16/25 at 9:30 AM she indicated she was an LPN. Nurse #2 stated when she completed an admission nursing assessment for a resident it was reviewed and signed by the Clinical Nurse Trainer or the Director of Nursing (DON). An interview conducted with Nurse #1 on 10/16/25 at 10:10 AM revealed she was an LPN and if a resident was admitted during her shift, she completed the admission nursing assessment. Nurse #1 indicated she was unsure if the assessments she completed were reviewed or signed by an RN. An interview was conducted with the Clinical Nurse Trainer on 10/16/25 at 10:20 AM. She stated an admission nursing assessment was completed immediately when a resident was admitted to the facility. She stated the assessment was completed by an LPN if an RN was not on duty but was not reviewed or signed by an RN after completion. The Clinical Nurse Trainer revealed that admission nursing	L 061		

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L 061	Continued From page 7 assessments should be completed by the RN or reviewed and signed by an RN when completed by an LPN. An interview conducted with the DON on 10/16/25 at 12:10 PM revealed when a resident was admitted to the facility an admission nursing assessment was completed by the assigned nurse within 24 hours. She indicated admission assessments completed by an LPN were not reviewed or signed by an RN. The DON stated she was unaware that Resident #1 did not have an admission assessment completed and that it must have been an oversight. During an interview with the Administrator on 10/16/25 at 12:25 PM he stated a resident should have an admission assessment completed and/or reviewed and signed by an RN within 24 hours of admission to the facility.	L 061		
L 062	.2301(B) PATIENT ASSESSMENT AND CARE PLANNING 10A-13D.2301 (b) The facility shall perform, within 14 days of admission and at least annually, a comprehensive, accurate, documented assessment of each patient's capability to perform daily life functions. This comprehensive assessment shall be coordinated by a registered nurse and shall include at least the following: (1) current medical diagnoses; (2) medical status measurements, including current cognitive status, stability of current conditions and diseases, vital signs, and abnormal lab values and diagnostic tests that are a part of the medical history; (3) the patient's ability to perform activities of daily living, including the need for staff assistance and	L 062		

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L 062	Continued From page 8 assistive devices, and the patient's ability to make decisions; (4) presence of neurological or muscular deficits; (5) nutritional status measurements and requirements, including but not limited to height, weight, lab work, eating habits and preferences, and any dietary restrictions; (6) special care needs, including but not limited to pressure sores, enteral feedings, specialized rehabilitation services or respiratory care; (7) indicators of special needs related to patient behavior or mood, interpersonal relationships and other psychosocial needs; (8) facility's expectation of discharging the patient within the three months following admission; (9) condition of teeth and gums, and need and use of dentures or other dental appliances; (10) patient's ability and desire to take part in activities, including an assessment of the patient's normal routine and lifetime preferences; (11) patient's ability to improve in functional abilities through restorative care; (12) presence of visual, hearing or other sensory deficits; and (13) drug therapy. This Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a Registered Nurse (RN) coordinate the comprehensive resident assessment completed within 14 days of admission for 4 of 5 residents reviewed for resident assessments (Resident #1, Resident #2, Resident #3, and Resident #4). The findings included: a. Resident #4 was admitted to the facility on 10/17/23 with diagnoses including stroke and	L 062		

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L 062	Continued From page 9 altered mental status. The comprehensive nursing assessment dated 10/17/23 was completed and signed by Nurse #2 with credentials Licensed Practical Nurse (LPN). b. Resident #1 was admitted to the facility on 10/08/24 with diagnoses including Alzheimer's disease and congestive heart failure. A review of Resident #1's medical record revealed a comprehensive nursing assessment was not completed. c. Resident #2 was admitted to the facility on 10/09/24 with diagnoses including Alzheimer's disease, hypertension and osteoarthritis. Resident #2's comprehensive nursing assessment dated 10/09/24 was completed and signed by Nurse #3 with credentials LPN. d. Resident #3 was admitted to the facility on 8/22/25 with diagnoses including congestive heart failure, atrial fibrillation and stage 3 chronic kidney disease. Resident #3's comprehensive nursing assessment dated 8/22/25 was completed and signed by Nurse #1 with credentials LPN. During an interview conducted with Nurse #2 on 10/16/25 at 9:30 AM she indicated she was an LPN. Nurse #2 stated when a resident was admitted to her unit, she completed a comprehensive admission nursing assessment. Nurse #2 revealed the assessments she completed were reviewed and signed by the Clinical Nurse Trainer or the Director of Nursing (DON).	L 062		

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L 062	Continued From page 10 An interview conducted with Nurse #1 on 10/16/25 at 10:10 AM revealed she was an LPN and if a resident was admitted during her shift, she completed a comprehensive admission nursing assessment. Nurse #1 indicated she was unsure if the assessments she completed were reviewed or signed by an RN. An interview was conducted with the Clinical Nurse Trainer on 10/16/25 at 10:20 AM. She stated the admission nursing assessment and comprehensive nursing assessment were both completed immediately after a resident was admitted to the facility. She stated the assessment was completed by an LPN if an RN was not on duty and was not reviewed or signed by an RN after completion. The Clinical Nurse Trainer revealed that the admission and comprehensive nursing assessments should be completed by an RN however if the assessments were completed by an LPN then they should be reviewed and signed by an RN. An interview conducted with the DON on 10/16/25 at 12:10 PM revealed the initial admission assessment and comprehensive nursing assessment were completed within 24 hours of the resident's admission to the facility. She stated the assessment was completed by the assigned nurse and if the nurse was an LPN the assessment was not reviewed or signed by an RN after completion. The DON stated she was unaware that Resident #1 did not have an admission or comprehensive assessment completed and that it must have been an oversight. During an interview with the Administrator on 10/16/25 at 12:25 PM he stated the resident	L 062		

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L 062	Continued From page 11 admission and comprehensive assessments should be completed by an RN within the required timeframe and any assessments completed by an LPN should be reviewed and signed by an RN.	L 062		

Plan of Correction

Deficiency: Failure to submit a 5-day investigation report timely to DHHS as required by state/federal regulations.

Regulatory Reference: F609 - *§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.*

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1. Corrective Action Taken for the Specific Deficiency:

The delay in submission was identified on October 15, 2025, and the summary report was presented to the surveyor team on that day. The formal 5-Day Working Report and fax confirmation that would have been due by March 6, 2024, was never produced.

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2. Identification of Other Residents Who Could Be Affected:

A review of all incident investigations completed over the last 90 days was conducted to determine if any additional 5-day investigation reports were submitted late. No other late submissions were identified.

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3. Systemic Changes to Prevent Recurrence:

- The facility's **Abuse Prevention Policy** has been revised to include:
    - Clear timelines for submission (24-hour initial report; 5-day investigation)
    - Defined roles and responsibilities for incident tracking and reporting
- A **5-Day Report Tracking Log** has been implemented to monitor deadlines from the date of the initial report.
- The Administrator or designee will review all reportable incidents to ensure timely submission.

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4. Training and Education:

- The Administrator and Nurse Educator provided **mandatory training** to all department heads, nurses, and key staff by 10/31/25 on:
    - State/federal reporting timelines
    - Revised Abuse Prevention Policy
    - Documentation requirements for investigations
    - Use of the tracking log and internal workflow updates
- New hire orientation materials have been updated to include this training module.

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5. Monitoring and Quality Assurance:

- The Administrator or designee will conduct **weekly audits** of all reportable incidents for the next **90 days** to verify timely submissions.
- Audit results will be reviewed during **monthly QAPI meetings**, and corrective action will be taken as needed.
- After 90 days, audits will continue **monthly for an additional 3 months**, with re-evaluation at that time for ongoing frequency.

Completion Date:

All corrective actions will be completed by: **November 1, 2025**

Responsible Party:

Cam Cecil, Administrator

Plan of Correction

Deficiency: Failure to ensure a resident was assessed by a Registered Nurse within 24 hours of admission for 4 of 5 residents reviewed.

Regulatory Reference: *L061 – 10A-13D.2301 (a) At the time each patient is admitted, the facility shall ensure medical orders are available for the patient's immediate care and that, within 24 hours, a nursing assessment of immediate needs is completed by a registered nurse and measures implemented as appropriate.*

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1. Corrective Action Taken for the Specific Deficiency:

The assessments found out of compliance with *L061 – 10A-13D.2301 (a)* for Residents still residing in the facility were reassessed and signed off by a Registered Nurse.

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2. Identification of Other Residents Who Could Be Affected:

A review of all admission assessments for those still in facility completed over the last 90 days was conducted to determine if any additional assessment had not been signed or co-signed by a Registered Nurse. Audit completed by 10/27/25.

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3. Systemic Changes to Prevent Recurrence:

- The facility's **EHR Admission Assessment** has been revised to include:
    - Co-sign option for times that LPNs are performing the admission assessment.
    - Admission Assessment are set to automatically send a notification to RNs when the assessment is completed and requires an RN's review.
- An **Admission Assessment Tracking Log** has been implemented to monitor 24-hour deadlines from the time of admission.
- The Director of Nursing or designee will review Admission Assessments at weekly RISK meeting to ensure compliant submission.

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4. Training and Education:

- By 10/31/25, the DON and/or Nurse Educator provided **mandatory training** to all Nurses on:
    - The *L061 – 10A-13D.2301 (a)* regulation
    - Documentation requirements for Admission Assessments
    - Use of the tracking log and internal workflow updates
- New hire nurse orientation materials have been updated to include this training module.

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5. Monitoring and Quality Assurance:

- The Director of Nursing or designee will conduct **weekly audits** of all admissions to verify Admission Assessments are compliant for the next **90 days.**
- Audit results will be reviewed during **monthly QAPI meetings,** and corrective action will be taken as needed.
- After 90 days, audits will continue **monthly for an additional 3 months,** with re-evaluation at that time for ongoing frequency.

Completion Date:

All corrective actions will be completed by: **November 1, 2025**

Responsible Party:

Patricia Capyak, RN, Director of Nursing

Plan of Correction

Deficiency: Failure to have a Registered Nurse (RN) coordinate the comprehensive resident assessment completed within 14 days of admission for 4 of 5 residents reviewed.

Regulatory Reference: *L061 – 10A-13D.2301 (b) The facility shall perform, within 14 days of admission and at least annually, a comprehensive, accurate, documented assessment of each patient's capability to perform daily life functions.*

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1. Corrective Action Taken for the Specific Deficiency:

The assessments found out of compliance with *L061 – 10A-13D.2301 (b)* for Residents still residing in the facility were reassessed and signed off by a Registered Nurse.

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2. Identification of Other Residents Who Could Be Affected:

A review of all admission assessments for those still in facility completed over the last 90 days was conducted to determine if any additional assessment had not been signed or co-signed by a Registered Nurse. Audit completed by 10/27/25.

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3. Systemic Changes to Prevent Recurrence:

- The facility's **EHR Comprehensive Assessment** has been revised to include:
    - Co-sign option for times that LPNs are performing the comprehensive assessment.
    - Comprehensive Assessments are set to automatically send a notification to RNs when the assessment is completed and requires an RN's review.
    - Comprehensive Assessments are scheduled tasked in EHR for timely completion.
- The Director of Nursing or designee will review Admission Assessments at weekly RISK meeting to ensure compliant submission.

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4. Training and Education:

- By 10/31/25, the DON and/or Nurse Educator provided **mandatory training** to all Nurses on:
    - The *L061 – 10A-13D.2301 (b)* regulation
    - Documentation requirements for Comprehensive Assessments
- New hire nurse orientation materials have been updated to include this training module.

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5. Monitoring and Quality Assurance:

- The Director of Nursing or designee will conduct **weekly audits** of all admissions to verify Comprehensive Assessments are compliant for the next **90 days**.
- Audit results will be reviewed during **monthly QAPI meetings**, and corrective action will be taken as needed.
- After 90 days, audits will continue **monthly for an additional 3 months**, with re-evaluation at that time for ongoing frequency.

Completion Date:

All corrective actions will be completed by: **November 1, 2025**

Responsible Party:

Patricia Capyak, RN, Director of Nursing