STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Care of King	**440 Ingram Road , King, North Carolina, 27021**

(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) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 1/5/26 through 1/8/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1DF6B8-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/05/26 through 01/08/26. Event ID #1DF6B8-H1. The following intakes were investigated: 2700039, 2669851, 2656374, 2656574, 2627060, 2630565, 2638143, 870134, 870086, 870132, 870130, and 870133. 0 of the 45 complaint allegations resulted in deficiency.	F0000		
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or	F0645		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0645 SS = D	Continued from page 1 (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.	F0645		

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F0645 SS = D	Continued from page 2 This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to submit a request for an evaluation for a Level II Preadmission Screening and Resident Review (PASRR) for a resident with a serious mental health disorder for 1 of 3 residents reviewed for PASRR (Resident #96). Findings included: A PASRR Determination Notification letter dated 10/24/22 revealed Resident #96 had a Level I PASRR with no expiration date. Resident #96 was admitted to the facility on 4/18/25 with diagnoses that included major depression, post-traumatic stress disorder (PTSD), and anxiety. The admission Minimum Data Set (MDS) assessment dated 4/24/25 revealed Resident #96 had a serious mental illness and/or intellectual disability. He received antidepressant medication during the MDS assessment period. Pertinent diagnoses included major depression, insomnia, anxiety, and PTSD. A Psychiatric progress note dated 9/29/25 revealed Resident #96 was seen for evaluation of major depressive disorder, PTSD, and insomnia. He was taking duloxetine (an antidepressant) daily for depression and trazodone (an antidepressant) for depression and insomnia. It was noted Resident #96 had no significant mood or anxiety concerns at that time and no changes to the medication was needed. Review of Resident #96's medical record revealed there was no evidence of a Level II PASRR evaluation. The facility was unable to provide documentation that a request for an evaluation for a Level II PASRR had been submitted for Resident #96. During an interview on 1/8/26 at 2:48 PM with the Social Worker (SW) she stated Resident #96 came in with a Level 1 PASRR when he was admitted in April 2025 and she had not submitted a request for an evaluation for a Level II PASRR for him. The SW stated that the facility team usually discussed new admits during morning meetings and that was how she would know that a new admission needed PASRR screening. The SW stated she must have inadvertently missed submitting one for Resident #96.	F0645		

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F0645 SS = D	Continued from page 3 During an interview on 12/04/25 at 2:00 PM, the Administrator revealed she started employment at the facility a little over a year ago and was not sure if requests for evaluations for Level II PASRR had been submitted for Resident #96 or any resident. The Administrator stated she would expect the SW to submit a request for a new evaluation for a Level II PASRR if a resident was admitted with a serious mental health diagnosis even if they had a Level 1 done previously by another facility.	F0645		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was	F0656		

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F0656 SS = D	Continued from page 4 assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to develop comprehensive care plans addressing behaviors and post-traumatic stress disorder (Resident #96) and hospice care (Resident #13) for 2 of 19 residents reviewed. The findings included: 1. Resident #96 was admitted to the facility on 4/18/25 with diagnoses that included major depression, post-traumatic stress disorder (PTSD), and anxiety. The admission Minimum Data Set (MDS) assessment (4/24/25) indicated Resident #96 was cognitively intact and was marked as having major depression, PTSD and anxiety. Resident #96 was not marked for any behaviors and received two antidepressants during the assessment period. The most recent quarterly MDS dated 10/25/25 did not include any behaviors. Review of Psychiatric note dated (9/29/25) confirmed diagnoses of major depressive disorder, PTSD, and insomnia; medications included duloxetine (antidepressant) daily for depression and trazodone (antidepressant) for depression and insomnia. It was noted Resident #96 had no significant mood or anxiety concerns at that time and no changes to the medication regimen. Review of nurse progress notes from September 2025 to present documented verbal abuse toward staff and refusal of weights and blood draws.	F0656		

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F0656 SS = D	Continued from page 5 Review of Resident #96's comprehensive care plan dated 4/24/25 (last revised 12/22/25) included depression, antidepressant use, and rejection of care. There were no care plans that addressed the resident's verbal behaviors and PTSD diagnosis. During an interview with Nurse Aide #1 on 1/8/26 at 10:36 AM, she stated Resident #96 was alert and oriented and could make his needs known. She stated he was also challenging to care for at times due to refusal of care. Nurse Aide #1 stated they will usually take 2 aides in and if he is in "one of his moods", they will leave the room, allow him to calm down, and then attempt the care again. During an interview with the MDS nurse on 1/8/26 at 1:48 PM, she stated that Resident #96 was not marked for behaviors on any of the MDS's since admission because they weren't everyday occurrences so there may not have been any specific verbal behaviors during his look back period. The MDS nurse stated she thought the Social Worker did the care plans for mental illness and behavior needs. During an interview on 1/8/26 at 2:08 PM with the Social Worker (SW) she stated she did not do any portions of the care plans, adding that the nursing staff would do those. During an interview with the Director of Nursing on 1/8/26 at 2:20 PM, she stated that she was aware of Resident #96's behaviors and stated he should have been care planned for verbal behaviors against staff, as well as PTSD which was stable and followed by psychiatry. The DON further stated that there was not one person responsible for creating care plans and that any nurse could update the care plan as needed and the facility would be looking into creating a process. 2. Resident # 13 was re-admitted 11/8/25 with hospice services following hospitalization; hospice services began 11/10/25. Review of the hospice provider notes indicated Resident #13 was accepted into hospice care services on 11/10/25. Resident #13's care plan (last revised 9/19/25) lacked a focus area, goals, or interventions for hospice care. Review of the significant change Minimum Data Set (MDS)	F0656		

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F0656 SS = D	Continued from page 6 assessment (11/12/25) confirmed hospice services. During an interview on 1/8/25 at 2:30 PM with the MDS Nurse #1, she stated hospice care services should have been included in the care plan for Resident #13. The MDS nurse indicated there wasn't just one person responsible for care plans and that any nurse could update the care plan as needed. During an interview with the Director of Nursing on 1/8/25 at 2:25 PM, she stated that not adding Hospice to Resident #13's care plan was an oversight and she revealed her expectation would have been that hospice care services were included in the care plan for Resident #13. The DON further stated that there was not one person responsible for creating care plans and that any nurse could update the care plan as needed and the facility would be looking into creating a process.	F0656		
F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and	F0865		

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F0865 SS = F	Continued from page 7 §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;	F0865		

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F0865 SS = F	Continued from page 8 §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on record review and Administrator interview, the facility failed to maintain and produce documented evidence of a comprehensive and ongoing Quality Assurance and Performance Improvement program that demonstrated systematic identification, reporting, investigation, analysis, and prevention of adverse events; and the development, implementation, and evaluation of corrective actions or performance improvement activities for calendar year 2025. This deficient practice had the potential to affect all 94 of 94 facility residents. Findings included: Review of the facility's 2025 Quality Assurance and Performance Improvement plan policy revealed outlined principles of making resident care decisions based on data, goal setting for performance, the measurement of progress towards said goals and the utilization of all collected quality improvement data to guide day-to-day	F0865		

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F0865 SS = F	Continued from page 9 operations within the facility. Review of the Quality Assurance and Performance Improvement committee meeting minutes from January 2025 through December 2025 revealed signatures of interdisciplinary staff members in attendance at each months' meeting. However, the reviewed meeting minutes contained no documentation of topics discussed, no identified concerns, no data tracking of concerns nor any measures taken or planned to address any such concerns in the form of a Performance Improvement Plan. In an interview with the Administrator on 1/8/26 at 3:40 PM, the Administrator said the Quality Assurance and Performance Improvement committee met every month. The Administrator said they conducted their meetings in person but used a computer-based documenting system, and they did not take down formal meeting minutes. The Administrator said that concerns were discussed verbally. The Administrator was unable to provide documentation of any identified concerns, data tracking or goals nor any ongoing Performance Improvement Plans for calendar year 2025 from the computer-based system utilized by the facility nor from any other source. She revealed there were in fact no formal ongoing Performance Improvement Plans occurring at the time of this interview nor for the previous calendar year 2025. The Administrator said that she realized it was very important to have a complete Quality Assurance and Performance Improvement plan and that it was very important to document the meeting minutes and discussion of concerns as well as to track those concerns. She indicated she would be ensuring this was done going forward.	F0865		