STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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, NC 27021

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnoses that included major depression, post-traumatic stress disorder (PTSD), and anxiety.The admission Minimum Data Set (MDS) assessment dated [DATE] 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.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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] 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. 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 [DATE] 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) 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.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 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 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.