STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, a follow-up survey, and complaint investigation on November 12-14, 2025. The complaint was initiated by the Richmond County Department of Social Services on October 29, 2025.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide a safe and clean environment related to the presence of live and dead cockroaches throughout the facility and failed to maintain an environment free of hazards as evidenced by an unlocked closet containing cleaning products accessible to the residents living on the Special Care Unit (SCU). The findings are:	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 079	Continued From page 1 Review of the Richmond County Public Health Inspection Report for the kitchen dated 08/25/25 revealed the facility was out of compliance and deducted points for insects and rodents. Review of the Richmond County Public Health Inspection Report for the facility dated 09/23/25 revealed the facility was out of compliance and deducted points for pest control. Observation of the facility kitchen on 11/12/25 at 2:54pm and 11/13/25 at 7:48am revealed live and dead cockroaches throughout the kitchen. Observation of medication cart on 11/13/25 at 3:30pm revealed a live cockroach on top of the medication cart. Interview with resident in room 13 on 11/12/25 at 9:00am revealed she has issues with roaches in her room. Interview with a resident in room 11 on 11/12/25 at 9:20am revealed : -He observed roaches in his bedroom. -Pest control came to the facility and sprayed but not regularly. Interview with a resident in room 6 on 11/12/25 at 11:10am revealed he had seen roaches in the dayroom and in the dining room. Observation of room 15 on 11/14/25 at 10:00am revealed there was a live cockroach on the closet door. Interview with a resident in room 15 on 11/14/25 at 10:00am revealed : -She saw a lot of roaches in her room at night. -She saw roaches in the facility daily.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 079	Continued From page 2 Interview with a housekeeper on 11/12/25 at 9:30am revealed: -The facility has always had an issue with roaches. -Pest control came to the facility monthly to spray for bugs. Interview with a personal care aide (PCA) on 11/12/25 at 10:40am revealed: -The facility was infested with roaches. -Pest control did not come and spray for bugs as much as they needed to. Interview with the Maintenance Director on 11/12/25 at 11:00am revealed: -He did not believe there was an issue with roaches in the facility. -He had seen a few roaches throughout the facility. -He believed the roaches in the facility were caused by residents that kept food inside of their rooms. -The exterminator came to the facility to spray for pests monthly. Interview with the Resident Care Coordinator (RCC) on 11/12/25 at 2:30pm revealed: -Residents had complained to staff about bugs in the facility. -She had observed roaches in resident rooms and at the nursing stations. -Pest control came to the facility to spray for bugs every other month. Interview with the Dietary Manager on 11/13/25 at 8:45am revealed: -She had not observed pest control come and spray the kitchen in the past month. -She had observed roaches in the kitchen.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 079	Continued From page 3	D 079		

-She began to get rid of all the cardboard boxes in the pantry and in the kitchen in order to help get rid of the roaches in the kitchen.
-She had seen less roaches in the kitchen in the past couple of weeks.
-She was concerned about roaches in the kitchen because they were unsanitary and carried germs.

Interview with the Administrator on 11/14/25 at 9:30am revealed:
-He was aware that the facility had issues with roaches throughout the facility.
-The facility had a contract with a pest control company.
-The pest control technician came out monthly and upon request to spray for insects.
-He had taken measures to get rid of the roaches in the facility by getting rid of old furniture and limiting foods residents could have in their rooms.
-The housekeepers cleaned residents' rooms daily.
-He was concerned with sanitation in the kitchen and throughout the facility if roaches were present.

Interview with the pest control technician on 11/14/25 at 10:30am revealed:
-He was at the facility to spray for insects and inspect the facility for roaches.
-He had been the pest control technician for this facility for several years.
-He had not come out to the facility to spray July through September because the facility had not paid the company for services.
-He resumed treating the facility for insects in October.
-He usually came to the facility to treat for roaches and other insects monthly.
-The facility still had issues with roaches throughout the facility and in the kitchen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 079	Continued From page 4 -The facility did not have a serious infestation and it appeared to be getting better than it had been in the past. 2. Review of the facility Special Care Unit (SCU) census on 11/12/25 revealed a census of 41 residents. Observation of the SCU on 11/12/25 during the initial tour at 9:15am revealed: -Residents ambulated freely in the halls to and from their rooms and to the other areas of the SCU. -One of two doors labeled as "janitor's closet" was unlocked. -Several chemicals were present in the janitor's closet, including a concentrated cleaner labeled as "Danger: corrosive-causes irreversible eye damage", "harmful if absorbed through skin", "harmful if swallowed", and "do not get in eyes, skin, or on clothing". -The warnings on the concentrated cleaner label advised to immediately call a doctor if the product got in the eyes, on skin, or if swallowed. Interview with a personal care aide (PCA) on 11/12/25 at 9:20am revealed: -She thought the janitor's closet was locked. -She denied that any resident had attempted to ingest non-food items. -The janitor's closet was normally locked. -She did not know why the closet was unlocked. Interview with the Housekeeping Supervisor on 11/14/25 at 8:50am revealed: -The facility kept a housekeeping cart in the janitor's closet in the SCU in case night shift needed to use it to clean. -She usually checked the closet door when she	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 079	Continued From page 5	D 079		

arrived at work to ensure it was locked, but she arrived late on 11/12/25.
-She rarely found the janitor's closet door on the SCU unlocked, but it happened occasionally.
-The blue concentrated cleaner was dangerous and could cause injury to residents if the cleaner came in contact with their eyes, skin, or if they ingested it.
-All rooms containing chemicals were supposed to be locked at all times when a staff member was not present in the room and staff were supposed to triple check the door to ensure it was locked.

Interview with the Special Care Coordinator (SCC) on 11/12/25 at 9:24am revealed:
-The closet door was supposed to be locked at all times.
-She was not aware of any residents attempting to ingest non-food items.
-She immediately locked it to prevent residents from accessing the dangerous chemical contained in the closet.

Second interview with the SCC on 11/12/25 at 3:15pm revealed:
-She had not found the closet door unlocked in months, but it was left unlocked "occasionally".
-The janitor's closet should always remain locked to ensure residents did not access the chemicals in the closet and cause harm to themselves.

Interview with the Administrator on 11/12/25 at 3:10pm revealed:
-The closet door should not have been unlocked and the doors are supposed to be set to lock automatically once closed.
-The doors and locks were old and must have mechanically failed to engage the lock.
-Any door separating residents from chemicals

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 079	Continued From page 6 that could cause harm should have been locked at all times unless a staff member was in the room. -Residents could have gotten the cleaning agent in their eyes, on their skin, or ingested the chemical and been greatly harmed.	D 079		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for 20 of 20 fixtures located in resident in assisted living. The findings are: Observation of water temperatures on 11/12/25 from 8:40am to 9:30am in resident bathrooms revealed: -There was little to no water pressure for the hot water in the bathrooms on the left wing of assisted living.	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 113	Continued From page 7 -In room 1 the hot water temperature of the sink was 52.7°F. -In room 5 the hot water temperature of the sink was 63.5°F. -In room 15 the hot water temperature of the sink was 57.0°F. Interview with a resident residing in room 12 on 11/12/25 at 9:15am revealed: -The hot water in his bathroom had not been working for about a week. -He had to go to the spa on the other side of assisted living in order to shower. Interview with a resident residing in room 11 on 11/12/25 at 9:30am revealed: -The water heater on the left hall of assisted living was not working. -He had to go to the spa in the right hall of assisted living in order to take showers. -He was not sure how long the water heater had not been working. Interview with a housekeeper on 11/12/25 at 9:50am revealed: -The hot water heater on the left hall of assisted living had been broken for approximately two weeks. -The residents on the left hall were taken to the spa on the right hall of assisted living to get showers. Interview with a personal care aide (PCA) on 11/12/25 at 10:40am revealed: -The hot water on the left hall had been out for three weeks to a month. -The residents on the left hall had to go to the spa on the right hall to take showers. -When she gave residents on the left hall bed baths she had to warm the water up in the	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 113	Continued From page 8	D 113		

resident's microwaves.

Interview with a Maintenance Manager on 11/12/25 at 11:30am revealed:
-The hot water heater on the left hall had been broken for about a ten days.
-The facility ordered a new water heater when it broke, they were waiting on the new water heater to be delivered.
-Residents on the left hall were using the spa room on the right hall to shower.
-He was responsible for the water temperatures in the facility being in range.

Interview with the Resident Care Coordinator (RCC) on 11/12/25 at 2:30pm revealed:
-The water heater on the left hall in assisted living had been broken for about two weeks.
-The residents on the left hall were using the spa room on the right hall to take showers and baths.
-She was not sure why the water heater had not been fixed or replaced.
-The Maintenance Director was responsible for ensuring the water temperatures in the facility were within proper range.
-It was important for residents to have hot water in their bathrooms for proper hygiene and to wash hands.

Interview with the Administrator on 11/13/25 at 9:30am revealed:
-The hot water on the left hall had been out for about a week.
-The new hot water heater had been ordered and was scheduled to be installed on 11/14/25.
-The residents on the Anson Hall were using the spa room on the Scotland Hall to take showers.
-Residents having hot water in their bathrooms was a top priority so they are able to wash their hands and be able to shower and take baths in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 113	Continued From page 9 the spa room on their hall.	D 113		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents were provided with non-disposable place settings including plates, bowls, forks, knives, spoons, and cups during meal service. The findings are: Observation on 11/13/25 at 7:10am revealed: -A dietary staff brought out a black utility cart with two shelves. -On the top shelf of the cart there were several white disposable foam cups filled with different liquids, white liquid (milk), orange-colored drink (orange juice), clear liquid (water), and a dark liquid with steam noted from the top (coffee). -There were no lids on the cups nor were they covered with any other coverings.	D 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 286	Continued From page 10 -On the tables, there were white disposable foam cups, paper napkins, and disposable foam plates with breakfast food that included toast, scrambled eggs and grits. -The residents used white plastic cutlery to eat their breakfast. Observation of a resident's breakfast meal service on 11/13/25 at 7:30am through 8:00am revealed: -The residents on assisted living were served breakfast in the dining room on disposable place settings. -The residents were served on disposable bowls, disposable plates, disposable cups, with plastic cutlery. -The residents on special care unit were served breakfast in the dining room on disposable place settings. -The residents were served on disposable bowls, disposable plates, disposable cups, with plastic cutlery. Interview with a dietary aide on 11/13/25 at 9:06am revealed: -The dishwasher in the facility had been broken for two to three months. -The residents had been served on disposable dishes since the dishwasher first broke. Interview with the Dietary Manager on 11/13/25 at 8:45am revealed: -Disposable plates, cups and utensils had been used for the residents in the facility for approximately a month. -The dishwasher had been broken for at least a month. -She was aware that residents should be served on non-disposable dishware. -It was important for residents to be served on	D 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 286	Continued From page 11 non-disposable dishware to make the environment feel more like home. Interview with the Resident Care Coordinator (RCC) on 11/13/25 at 9:20am revealed: -She was not sure how long the dishwasher had been broken. -The residents were all served meals with disposable bowls, disposable plates, disposable cups, with a plastic cutlery since the dishwasher broke. -She was not aware that residents were not supposed to be served meals on disposable dishware. Interview with the Administrator on 11/13/25 at 9:45am revealed: -The residents were being served on disposable dishware because the dishwasher was broken. -The dishwasher in the facility had been broken for a few weeks. -There was a three week backorder for the dishwasher that the facility used. -He was aware that the facility should not serve residents on disposable dishware. -It was an issue with dignity for the residents to be served meals on non-disposable dishware and cutlery.	D 286		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 338	Continued From page 12	D 338		

Based on observations, interviews, and record reviews, the facility failed to ensure appropriate care was provided to 1 of 6 sampled residents (#6) related to properly securing a resident in a wheelchair during transport.

The findings are:

Review of the facility Emergency and Accident Policy revealed the policy included the following:
-An emergency was a situation which arose suddenly and called for prompt action.
-An accident was an unexpected, unplanned event, which may or may not cause injury.
-The staff were to remain calm, remove the resident from immediate danger if possible, , send or call for help, evaluate the situation and call or ask someone to call 911 if necessary.
-The policy was not dated.

Review of Resident #6's current FL-2 dated 04/23/25 revealed:
-Diagnoses included Alzheimer dementia, hemiplegia, history of transient ischemic attacks/strokes, seizure disorder, and history of falls.
-The resident required the use of a wheelchair for ambulation.
-Functional limitations for Resident #6 included speech and contractures.

Review of the Resident Register for Resident #6 dated 05/23/24 revealed:
-Resident #6's date of admission to the facility was 05/23/24.
-There were two family members listed as Power of Attorney (POA) for the resident.

Review of Resident #6's Quarterly Assessment dated 09/14/25 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 338	Continued From page 13	D 338		

-Resident #6 required assistance with dressing, and at times required assistance with transferring and toileting.
-The resident used a wheelchair for mobility and was able to self-propel the wheelchair.
-The resident was intermittently disoriented.
-Resident #6 was a moderate risk for falls.

Telephone interview with Resident #6 on 11/13/25 at 4:44pm revealed:
-He was not fully buckled in the wheelchair seat during the transport incident on 10/07/25.
-Only one side of the wheelchair was buckled.
-There was no seat belt.
-He slid out of the wheelchair.
-The wheelchair rocked back and forth.
-He was on the floor for about ½ hour.
-The transporter did not try to pull over or call for help.
-He remembered hearing a family member's voice when he arrived at the appointment location.

Telephone interview with a POA for Resident #6 on 11/12/25 at 2:30pm revealed:
-Resident #6 fell on the bus on 10/07/25 when he was being transported to an oncology appointment in another city.
-The transporter drove the facility van to the hospital with Resident #6 on the floor.
-Resident #6 reported to the POA that he was not buckled in and was sliding on the floor of the van for 30 - 40 minutes.
-The resident was seen by the oncologist who referred the resident to the hospital.

Second telephone interview with a POA for Resident #6 on 11/13/25 at 9:47am revealed:
-Resident #6 had a follow-up appointment on 10/07/25 at the oncology office.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 338	Continued From page 14	D 338		

-When the facility transporter arrived at the appointment, the POA went to the transport van and Resident #6 was on the floor of the van.
-She saw a foamy white substance on Resident #6's lips.
-The resident told her that he was "okay, alright" and had hit his buttocks and leg.
-The resident had been on the floor of the van for 30 - 40 minutes.
-The POA called the guard at the appointment office gate for assistance.
-Only the wheels on the right side of the wheelchair were secured, and there was no seat belt on the resident.

Interview with a personal care aide (PCA) on 11/13/25 at 7:05am revealed:
-Resident #6 would slide out of his wheelchair.
-Staff would assist him and "the next thing you know he would slide down in the wheelchair".
-Resident #6 would say he knew he was sliding in the wheelchair when he was asked if he knew he was sliding.

Telephone interview with the security guard at Resident #6's oncology office complex gate on 11/13/25 at 10:43am revealed:
-Resident #6's family member notified her that Resident #6 was on the floor of the transport van.
-She asked the family member if the resident was in distress which the family member denied and said the resident was "fine to her knowledge".
-She activated a rapid response call for assistance to get Resident #6 off the floor of the transport van.
-When a team of nursing staff arrived to assist Resident #6, the staff spoke to Resident #6 (content of conversation not provided).
-When she saw Resident #6, he was positioned in the back of the transport van on his side, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 338	Continued From page 15	D 338		

she was unsure which side he was positioned on.
-The family member told the security guard that she had received a call from the transporter that Resident #6 had fallen while being transported to the oncology appointment.

Second telephone interview with the security guard at Resident #6's oncology office complex gate on 11/14/25 at 11:59am revealed she had contact with a few of the staff who assisted Resident #6 off the floor of the van, and they were not able to provide any information about the incident.

Telephone interview with Resident #6's oncology Physician Assistant (PA) on 11/13/25 at 11:15am revealed:
-Resident #6 was presenting for a routine follow up appointment on 10/07/25.
-The family member made the PA aware Resident #6 had fallen out of the wheelchair while in transport for the appointment.
-There was no pain verbalized and Resident #6 declined to go to the hospital emergency department (ED).
-She saw Resident #6 an hour or so after the rapid response team assisted in getting the resident off the floor of the transport van and into the medical office.
-The PA had never seen Resident #6 so she did not have any previous comparison for the resident.
-Resident #6 did not seem in any acute distress and she did not notice any swelling.
-Resident #6 seemed tired and said he had not hit his head.
-The family members informed the PA that they noticed changes in Resident #6 and wanted the resident seen in the ER.
-She recommended the resident be seen in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 338	Continued From page 16	D 338		

ED since the family members were reporting changes in his mental status, and the office nurse wheeled Resident #6 to the ED.

Telephone interview with the former facility transporter on 11/13/25 at 3:31pm revealed:
-She transported Resident #6 to the 10/07/25 appointment in the facility van.
-She noticed the wheelchair locks were off the floor of the facility transport van before preparing for the appointment, so she put four of the eight wheelchair locks back on the floor.
-She noticed the floor of the van was slippery but did not give that any attention.
-Resident #6 was slipping down in the wheelchair as she got to the transport van for loading.
-She instructed Resident #6 to sit up in the wheelchair, and the resident did.
-During the trip to the appointment, Resident #6 informed the transporter that he was sliding out of his wheelchair.
-She pulled the van over and tried to push the resident back up in the wheelchair but was unable to do so.
-Resident #6 slid to the floor of the transport van into a sitting position.
-She took the cushion from the seat of the wheelchair and instructed Resident #6 to lay on the cushion until she got him to his appointment location.
-She had not used the shoulder strap to fasten Resident #6 in the transport van on 10/07/25.
-She did not really know why she did not use the shoulder strap to fasten Resident #6 securely in the transport van.

Telephone interview with Adult Home Specialist for the local Department of Social Services (DSS) on 11/14/25 at 12:45pm revealed that as soon as the Adult Protective Services (APS) case for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 338	Continued From page 17 Resident #6 was received the Supervisor completed their portion and the case was then turned over to the county DSS where Resident #6 now resided. Interview with the Administrator on 11/12/25 at 3:54pm revealed: -Resident #6 slid out of the wheelchair during transport to a medical appointment in another city (no date or time provided). -The transporter called the facility and reported that Resident #6 had fallen/slid out of the wheelchair (no time provided), and they were at the resident's appointment. -He believed Resident #6's family member was at the appointment. -Persons at the oncologist's office helped to get Resident #6 up off the floor of the facility van. -He talked to the family member and asked if Resident #6 needed to go to the hospital emergency room and the family member responded to let the oncologist look at Resident #6 and would see what recommendations were made. -The transporter informed him that Resident #6 slid out of the wheelchair, and she (transporter) was not able to catch the resident while he was sliding out of the wheelchair, so she helped the resident to slide to the floor, stabilized the resident by using the wheelchair cushion to prop the resident, and continued to travel to the oncology appointment with Resident #6 on the floor of the van. -The resident was seen by the oncologist for the scheduled appointment and oncologist recommended for Resident #6 to be seen at the ED. -The Administrator went to the hospital and talked to Resident #6 while he was waiting in the ED waiting area to be seen.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 338	Continued From page 18 Second interview with the Administrator on 11/14/25 at 12:06pm revealed: -If a resident had a slip or fall, he expected emergency medical service (EMS) to be called first and a phone call to the facility as soon as the resident was determined to be okay. -He would have expected the former transporter to have buckled and strapped Resident #6's wheelchair properly when transporting the resident in the facility van. -When he investigated the incident, the former transporter would not come out and say that she had not strapped Resident #6 in properly, but he was able to make the assumption because if the resident had been strapped in properly, the resident or wheelchair would not be able to fall. -He expected staff to use proper safety procedures to ensure resident safety during transport. Attempted telephone interview with Resident #6's local DSS Guardian on 11/14/25 at 11:54am was unsuccessful. Attempted telephone interview with local DSS APS staff on 11/14/25 at 11:58am was unsuccessful. Attempted telephone interview with Resident #6's oncology staff on 11/14/25 at 12:01pm was unsuccessful. Attempted telephone interview with the local Department of Social Services Guardian regarding Adult Protective Services case for Resident #6 on 11/14/25 at 11:54am was unsuccessful. Attempted telephone interview with the local	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 338	Continued From page 19 Department of Social Services Adult Protective Services regarding case for Resident #6 on 11/14/25 at 11:58am was unsuccessful. Attempted telephone interview with Resident #6's oncology staff on 11/14/25 at 12:01pm was unsuccessful.	D 338		
D 370	10A NCAC 13F .1004 (m) Medication Administration 10A NCAC 13F .1004 Medication Administration (m) Medication administration supplies, such as graduated measuring devices, shall be available and used by facility staff in order for medications to be accurately and safely administered. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure graduated measuring devices were available for use by facility staff for 1 of 3 observed residents (#7) during medication pass in order for medications to be accurately and safely administered. The findings are: Review of Resident #7's current FL-2 dated 06/18/25 revealed diagnoses included hemiplegia, chronic pain syndrome, and anemia. Review of Resident #7's new prescription summary dated 11/07/25 revealed there was an order for guaifenesin 100mg/5mL syrup give 10mL three times daily for 5 days (guaifenesin is	D 370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 370	Continued From page 20	D 370		

used to treat cough and congestion).

Observation of the 8:00am medication pass from 7:30am to 8:20am on 11/13/25 revealed:
-The medication aide (MA) prepared guaifenesin 100mg/5mL liquid for Resident #7 by pouring the liquid about halfway up a small, clear, non-graduated medication cup.
-Resident #7 was administered the unmeasured amount of guaifenesin at 7:41am.

Observation of Resident #7's medications on hand on 11/13/25 at 7:39am revealed instructions on the label of guaifenesin 100mg/5mL liquid were to administer 10mL three times daily and there was about two-thirds an amount remaining of a 16 ounce bottle dispensed on 11/08/25.

Review of Resident #7's November 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for guaifenesin 100mg/5mL give 10mL three times a day for 5 days from 11/08/25 through 11/13/25.
-Guaifenesin 100mg/5mL was documented as administered three times a day from 11/08/25 through the 7:30am dose on 11/13/25.

Interview with Resident #7 on 11/13/25 at 7:42am revealed her cough and cold symptoms had improved since receiving guaifenesin.

Interview with the MA on 11/13/25 at 7:45am revealed:
-She prepared an approximate dose of 10mL of guaifenesin for Resident #7 because the facility did not have any graduated measuring cups.
-The facility had been out of graduated medication cups for "a while".
-She had not reported the lack of graduated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	R 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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
D 370	Continued From page 21 medication administration supplies to any management member of the facility. Interview with the Resident Care Coordinator (RCC) on 11/13/25 at 9:45am revealed: -She was not aware that staff did not have graduated medication cups to measure and accurately administer liquid medications. -None of the MAs had reported the lack of supplies to her. -The medication cups arrived weekly with the grocery order and should have been present for use. -Residents could have potentially been over or under dosed on medication because graduated medication cups were not available for staff use. Interview with the Administrator on 11/13/25 at 10:15am revealed: -He was not aware that the staff did not have graduated measuring devices for use to measure liquid medications. -The facility recently changed supply companies, and they must not have sent the correct medication cups. -Residents could have been over or under dosed on medications without the use of a measuring device for liquid medications. Interview with Resident #7's primary care provider (PCP) on 11/14/25 at 10:04am revealed: -She was not aware that the facility did not have graduated medication cups for staff to utilize to measure liquid medication doses. -One of the fundamentals of medication administration was ensuring the right dose of a medication and staff should not have been administering medication if they could not accurately measure the medication dose.	D 370		