STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL067023	A. BUILDING: _____ B. WING _____	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONSLOW HOUSE	34 MCDANIEL DRIVE JACKSONVILLE, NC 28546

(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 and Onslow County Department of Social Services conducted complaint investigations on 05/28/26, 05/29/26 and 06/01/26. The complaint investigations were initiated by the Onslow County Department of Social Services on 05/13/26 and 05/18/26.	D 000		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the 24-hour initial reports and/or 5-day investigative reports for the health care personnel registry (HCPR) were completed as required and in a timely manner for 1 of 1 sampled residents (#7) who had injuries of unknown origin, including a fractured femur. The findings are: Review of the facility's Accidents/Falls/Disaster and Fire Safety Policy dated September 2021 revealed: -When an accident or an emergency occurred, staff should: Call for help, evaluate the situation, call 911 if necessary, assess the resident, administer first aid as appropriate, and notify the physician and responsible party. -If there was an injury, staff were to complete the report of accident and incident form.	D 438		

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D 438	Continued From page 1 -If the accident or incident required intervention greater than first aid the accident incident report form should have been sent to the local county Department of Social Services within 48 hours. Review of Resident #7's current FL-2 dated 08/22/25 revealed: -Diagnoses included Alzheimer's disease and hypertension. -The resident was constantly disoriented. -The resident was semi-ambulatory. -The resident was incontinent of bowel and bladder. -The resident required assistance with bathing and dressing. Review of Resident #7's Resident Register dated 01/26/23 revealed: -The resident was admitted to the facility on 01/26/23. -The resident required assistance with dressing, bathing, nail care, shaving, ambulation, getting in and out of bed, toileting, hair/grooming, skin care, mouth care, feeding, positioning/turning, scheduling appointments, and orientation to time and place. -The resident had significant memory loss and must be directed. -The resident used a walker. Review of Resident #7's current assessment and care plan dated 08/21/25 revealed: -The resident was ambulatory with a walker for short distance. -The resident used a wheelchair with staff assistance. -The resident needed assistance with activities of daily living (ADLs) and hygiene. -The resident required 2-to-3-person assistance, depending on the day.	D 438		

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-The resident had swelling to the ankles and had orders to wear thromboembolic deterrent (TED) hose.
-The resident was incontinent of bladder and occasionally incontinent of bowel.
-The resident was sometimes disoriented, was forgetful and needed reminders.
-The resident required extensive assistance by staff with toileting, ambulation, bathing, dressing, grooming and transferring.

Review of Resident #7's accident/incident report dated 05/11/26 at 11:15am revealed:
-The type of incident was documented was hospital transfer.
-Resident #7's left leg was swollen and the resident stated she was in pain.
-Resident #7 was gasping for breath as she tried to stand and sit up in her chair.
-The medication aide (MA) called and spoke with the primary care provider (PCP), and he advised that the resident be sent out for evaluation.
-Emergency Medical Services (EMS) was called to transport Resident #7 to the hospital for evaluation.
-Resident #7's family member was contacted.

Review of Resident #7's hospital history and physical dated 05/11/26 revealed:
-There was no report of fall or injury for Resident #7.
-Resident #7 had dementia and did not ambulate at baseline.
-Resident #7's knee x-ray showed a distal femoral fracture.

Review of Resident #1's record revealed no documentation of a 24-hour initial report or 5-day working report being completed and sent to the Health Care Personnel Registry (HCPR) for

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D 438	Continued From page 3 Resident #7's injuries of unknown origin on 05/11/26. Interview with Resident #7's family member on 05/28/26 at 2:42pm revealed: -He received a call from facility staff on 05/11/26 advising that Resident #7 had been transported to the hospital by EMS. -The facility staff member advised when she went to get Resident #7 up that morning, Resident #7 was screaming and crying in pain and stated her leg hurt badly. -The hospital found that Resident #7's femur was fractured. -Resident #7 was still in the hospital. -He had not been alerted of any falls or issues for Resident #7 prior to 05/11/26. -Resident #7 was diagnosed with dementia, required 2-person assistance and did not attempt to stand. -Staff assisted Resident #7 up and into the wheelchair. -Resident #7 suffered from swelling in her ankles. -Before 05/11/26, Resident #7 could bear weight on her legs with assistance and could take a couple of steps assisted. Interview with a MA on 05/28/26 at 3:49pm revealed: -Resident #7 required 2-3 staff members with transfers. -Resident #7 could pull herself up with the walker with assistance sometimes but could not get up on her own. -Resident #7 suffered from chronic leg swelling. -On 05/10/26, Resident #7 complained of left leg pain but there was nothing abnormal observed. -On 05/11/26, Resident #7's left leg was swollen more than normal, so the PCP was called. -On 05/11/26, Resident #7 gasped for air and was	D 438		

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breathing hard when they stood her up around breakfast time.
-The PCP called back after breakfast and advised that Resident #7 be sent to the hospital for evaluation for a possible blood clot.
-The hospital staff called on 05/11/26 and reported that Resident #7 had a fractured femur.
-There had been no reported falls for Resident #7.
-She did not know how Resident #7 sustained a fractured femur.

Second interview with a MA on 05/29/26 at 9:51am revealed:
-She called the PCP, EMS and completed the Incident/Accident report for Resident #7 on 05/11/26.
-When and Incident/Accident report was completed in the computer, facility management staff were automatically notified of the report electronically.
-Facility management staff had to put their credentials in to review the electronic Incident/Accident reports to close out the report.
-The facility management staff that were electronically notified of the Incident/Accident reports were the Resident Care Coordinator (RCC) and Administrator, but the RCC was no longer employed at the facility on 05/11/26.
-The previous Administrator acknowledged and closed out the Incident/Accident report.
-Once the hospital called and advised that Resident #7 had a fractured femur, the previous Administrator started investigating by talking to all the staff who worked that weekend to find out what happened.
-The previous Administrator checked to see if there had been any reports of falls for Resident #7 but did not find any reports.
-She was unsure if the 24-hour and 5-day reports

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were done.
-The previous Administrator was responsible for completing the 24-hour and 5-day reports.

Interview with the RCC on 05/29/26 at 10:52am revealed:
-She had been the RCC since January 2025.
-Resident #7 was relocated to the facility March 2026 from another facility, along with other residents, the RCC and Administrator of that facility.
-The RCC and Administrator of the relocated facility were no longer employed.
-She did not know what happened with Resident #7 because the Administrator for the relocated facility was still employed at the time of the incident and was responsible for Resident #7.
-When an Incident/Accident report was done, the RCC was notified.
-After reading the Incident/Accident report, the RCC spoke with the resident and staff
-If the incident was reportable, the Administrator was notified and the report was sent to upper management.
-When there was an injury of unknown origin, the MA notified the RCC and a 24-hour report and 5-day report were completed and submitted to the Department of Social Services (DSS) and the State.
-There was no documentation that a 24-hour report and 5-day report were sent to HCPR for Resident #7.

Second interview with the RCC on 06/01/26 at 10:18am revealed:
-Once the hospital call and reported that Resident #7 sustained a fracture and there was no Incident/Accident report for a fall, a 24-hour report should have been started.
-An investigation should have been completed

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and the 24-hour and 5-day reports should have been sent to HCPR.

Interview with the Administrator on 05/29/26 at 11:12am revealed:
-She had been the Administrator since 08/11/25.
-Resident #7 was relocated to the facility 03/24/26 from another facility, along with other residents, the RCC and Administrator of that facility.
-She had no contact with Resident #7 because the relocated facility's RCC and Administrator were present and the staff were attending to the relocated residents.
-She did not know what happened with Resident #7.
-Injuries of unknown origin required an Incident/Accident report, progress note, 24-hour report, and 5-day report with investigation.
-She was unsure if the previous Administrator for the relocated facility followed the process for injury of unknown origin or not because there was no documentation to show what happened to Resident #7 other than the Incident/Accident report.

Second interview with the Administrator on 06/01/26 at 10:12am revealed:
-The MA was responsible for completing Incident/Accident reports.
-The Administrator was responsible for completing the 24-hour and 5-day reports and sending the reports to HCPR, the Regional Clinical Director (RCD) and the Regional Vice President of Operations (RVPO).
-Resident #7's injury should have been reported to HCPR by the Administrator.

Interview with the RCD on 05/29/26 at 1:00pm revealed:
-The previous Administrator for Resident #7

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D 438	Continued From page 7 reported to her on 05/12/26 that Resident #7 sustained a fracture; after the hospital provided an update on 05/11/26. -When she asked the Administrator what happened to Resident #7, the Administrator told her the resident had a fall a few days prior but did not give any details about the fall. -She told the Administrator to add the past fall and the fracture to the Incident/Accident report. -She did not follow up to see if the Administrator added the fall and fracture to the Incident/Accident report. -Upon review of the Incident/Accident report today, 05/29/26, she saw that the Administrator did not add the additional information to the Incident/Accident report. -None of the staff knew what happened to Resident #7. -When there was an injury of unknown origin, the Administrator was to start a report within 24 hours and send the report to her, the DSS, and the RVPO. -The Administrator had 5 days to investigate what happened and to send that report to her, the RVPO and HCPR. -Staff stated the Administrator sent out a group text message asking what happened with Resident #7 but there was no documentation of an investigation for Resident #7. -The Administrator was still employed with the facility on 05/11/26. -She did not know why the Administrator did not complete the 24-hour or 5-day reports. Second interview with the RCD on 06/01/26 at 10:15am revealed Resident #7's injury should have been reported to HCPR because it was unknown if she had a fall which caused the fracture and injury of unknown origin.	D 438		

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D 438	Continued From page 8 Interview with Resident #7's PCP on 05/29/26 at 8:28am and 11:40am revealed: -Facility staff called him about Resident #7's leg pain and swelling on 05/11/26 and he instructed them to send her to the hospital for evaluation. -Resident #7 was non ambulatory with advanced dementia. -Resident #7 had chronic lower extremity edema so swelling was normal for her. -His instructing staff to send Resident #7 to the hospital meant the swelling was abnormal. -Resident #7 may not have had pain from the chronic leg swelling but was on medication for arthritic pain. -He had not received a report of a fall for Resident #7. -A distal femur fracture was a fracture of the bone closer to the knee and was difficult to fracture from a fall. -Because bones became thin with age, Resident #7 could have sustained the injury from the pressure of her own weight rather than from a fall.	D 438		