STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 and follow-up survey from 06/09/26 through 06/10/26.	D 000		
D 098	10A NCAC 13F .0308 (a) Fire Extinguishers 10A NCAC 13F .0308 Fire Extinguishers (a) At least one five pound or larger (net charge) A-B-C type fire extinguisher is required for each 2,500 square feet of floor area or fraction thereof. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that at least one five pound or larger A-B-C type fire extinguisher was available for each 2,500 square feet of floor area or fraction thereof. The findings are: Observation of the facility on 06/10/26 at 8:18am, 06/10/26 at 8:23am, and 06/10/26 at 8:28am revealed: -There was a red fire extinguisher hook at the end of the right hallway near the exit door. -There was no fire extinguisher or a sign to indicate a fire extinguisher around the fire extinguisher hook. -There was a red fire extinguisher hook at the end of the left hallway near the exit door. -There was no fire extinguisher or a sign to indicate a fire extinguisher around the fire extinguisher hook. -There was a red fire extinguisher hook at the main lobby around the entrance door to the facility. -There was no fire extinguisher or a sign to	D 098		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 098	Continued From page 1 indicate a fire extinguisher around the fire extinguisher hook. Review of the facility's Fire Extinguisher reports revealed the last fire inspection was completed on 07/07/25 with no outstanding notations. Review of the facility's Fire Rehearsals revealed last fire drill rehearsal was completed on 05/06/26 with quarterly fire drills completed for each shift from previous months. Interview with a medication aide (MA) on 06/10/26 at 9:45am revealed: -She was aware the fire extinguishers were not available in the hallways. -The fire extinguishers had not been available in the hallways since they were inspected and recharged in the middle of May 2026. -She had not communicated about the fire extinguishers being available in the hallways because the Manager was responsible for ensuring the fire extinguishers were available for use in the facility. Interview with the Resident Care Coordinator (RCC) on 06/10/26 at 10:15am revealed: -She was not aware the fire extinguishers were not available in the hallways because she had not paid attention that the fire extinguishers were missing. -She and the Manager were responsible for ensuring the fire extinguishers were available for use in the facility. Interview with the Manager on 06/10/26 at 8:45am revealed: -She was not aware the fire extinguishers were not available in the hallways until today (06/10/26) when the staff told her.	D 098		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 098	Continued From page 2 -She was aware she needed fire extinguishers for adequate coverage throughout the facility but she was not aware the fire extinguishers were not placed back on the fire extinguisher hooks since being inspected and recharged in May 2026. -She was responsible for ensuring the fire extinguishers were available for use in the facility. Interview with the Administrator on 06/10/26 at 10:25am revealed: -She was aware she needed fire extinguishers for adequate coverage throughout the facility. -She was not aware the fire extinguishers were not available in the hallways until today (06/10/26) when the Manager told her. -The Manager and the Maintenance Manager were responsible for ensuring the fire extinguishers were available for use in the facility and she expected the fire extinguishers to be available for use. Interview with the Maintenance Manager on 06/10/26 at 10:35am revealed: -He was aware he needed fire extinguishers for adequate coverage throughout the facility. -He was not aware the fire extinguishers were not placed back on the fire extinguisher hooks since being inspected and recharged in May 2026. -He and the Manager were responsible were responsible for ensuring the fire extinguishers were available for use but it had been overlooked because he was overwhelmed with different maintenance projects.	D 098		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 280	Continued From page 3 (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure quarterly Licensed Professional Health Support evaluations (LHPS) were completed by an LHPS nurse for 4 of 5 sampled residents (#1, #2, #3, #4) related to evaluating tasks including inhalation via nebulizer and oxygen as needed (#1), ambulation using a wheelchair and transferring(#2), obtaining finger stick blood sugar (FSBS), transferring, and ambulation (#3), and transferring, ambulation using a wheelchair, and wound care (#4). The findings are:	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 280	Continued From page 4	D 280		

1. Review of Resident #1's current FL2 dated 03/20/26 revealed:
-Diagnoses included anxiety, hypothyroidism, and insomnia.
-She was ambulatory.
-She was incontinent of bowel and of bladder.

Review of Resident #1's Resident Register revealed she was admitted to the facility on 02/16/23.

Review of Resident #1's care plan revealed Resident #1 required limited assistance with bathing activities of daily living needs.

Review of Resident #1's LHPS evaluation records revealed:
-There was no current quarterly LHPS evaluation available for review.
-The last quarterly LHPS evaluation available for review was dated 02/05/26 and Resident #1 was marked for inhalation via nebulizer and oxygen as needed tasks.

Observation of Resident #1 during the initial facility tour on 06/09/26 at 9:14am revealed:
-Resident #1 was seated on her bedside commode in her bedroom.
-Her oxygen tank was secured on the floor beside her bed.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/10/26 at 10:15am.

Refer to the interview with the Manager on 06/10/26 at 10:05am.

Refer to the interview with the Administrator on 06/10/26 at 10:25am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 280	Continued From page 5	D 280		

2. Review of Resident #2's current FL2 dated 06/02/25 revealed:
-Diagnoses included dementia, seizure disorder, and bladder retention.
-She was semi-ambulatory with a wheelchair.
-She was incontinent of bowel and of bladder.

Review of Resident #2's Resident Register revealed she was admitted to the facility on 05/14/24.

Review of Resident #2's care plan revealed Resident #2 required total assistance with toileting, ambulation, bathing, dressing, grooming, and transferring activities of daily living needs.

Review of Resident #2's LHPS evaluation records revealed:
-There was no current quarterly LHPS evaluation available for review.
-The last quarterly LHPS evaluation available for review was dated 02/05/26 and Resident #2 was marked for transferring and ambulation tasks.

Observation of Resident #2 during the breakfast meal service on 06/10/26 between 7:00am and 7:45am revealed the personal care aides (PCA) assisted Resident #2 with her wheelchair ambulation to the dining room.

Interview with a PCA on 06/10/26 at 9:30am revealed:
-PCAs assisted Resident #2 with transferring to her wheelchair most of the time during the day.
-She had assisted Resident #2 with her wheelchair ambulation to the dining room for mealtimes.

Interview with a medication aide (MA) on 06/10/26 at 9:40am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 280	Continued From page 6	D 280		

-PCAs assisted Resident #2 with transferring to her wheelchair most of the time during the day.
-Resident #2 required the PCAs to assist her with wheelchair ambulation to the dining room for mealtimes.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/10/26 at 10:15am.

Refer to the interview with the Manager on 06/10/26 at 10:05am.

Refer to the interview with the Administrator on 06/10/26 at 10:25am.

3. Review of Resident #3's current FL2 dated 06/24/25 revealed:
-Diagnoses included peripheral vascular dementia, hypertension, diabetes type 2, history of cerebrovascular accident, peripheral vascular disease, beta thalassemia, and history of thrombocytopenia.
-He was ambulatory.
-He was continent of the bowel and bladder.
-There was an order for FSBS checks once a day.

Review of Resident #3's Resident Register revealed he was admitted to the facility on 06/22/25.

Review of Resident #3's care plan revealed Resident #3 required limited assistance with bathing activities of daily living needs.

Review of Resident #3's LHPS evaluation records revealed:
-There was no current quarterly LHPS evaluation available for review.
-The last quarterly LHPS evaluation available for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 280	Continued From page 7	D 280		

review was dated 02/05/26 and Resident #3 was marked for transferring, ambulation, and FSBS tasks.

Review of Resident #3's April 2026 electronic medication administration record (eMAR) revealed:
-There was an entry to check FSBS once a day.
-There were FSBS values documented on the eMAR from 04/01/26 through 04/30/26.

Review of Resident #3's May 2026 eMAR revealed:
-There was an entry to check FSBS once a day.
-There were FSBS values documented on the eMAR from 05/01/26 through 05/31/26.

Review of Resident #3's June 2026 eMAR from 06/01/26 to 06/08/26 revealed:
-There was an entry to check FSBS once a day.
-There were FSBS values documented on the eMAR from 06/01/26 through 06/08/26.

Interview with a medication aide (MA) on 06/10/26 at 9:40am revealed:
-Resident #3 required FSBS checks from the MAs.
-She checked Resident #3's FSBS on 1st shift most of the time.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/10/26 at 10:15am.

Refer to the interview with the Manager on 06/10/26 at 10:05am.

Refer to the interview with the Administrator on 06/10/26 at 10:25am.

4. Review of Resident #4's current FL2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 280	Continued From page 8 11/10/25 revealed: -Diagnoses included dementia with behavior disturbance and neuropathic pain. -He was ambulatory with a wheelchair. -He was continent of bowel and of bladder. Observation of Resident #4 during the initial facility tour on 06/09/26 at 9:14am revealed he was seated in his wheelchair in the main lobby of the facility. Review of Resident #4's Resident Register revealed he was admitted to the facility on 10/24/24. Review of Resident #4's care plan revealed Resident #4 required limited assistance with toileting, ambulation, bathing, dressing, grooming, and transferring activities of daily living needs. Review of Resident #4's LHPS evaluation records revealed: -There was no current quarterly LHPS evaluation available for review. -The last quarterly LHPS evaluation available for review was dated 02/05/26 and Resident #4 was marked for transferring, ambulation, and wound care tasks. Refer to the interview with the Resident Care Coordinator (RCC) on 06/10/26 at 10:15am. Refer to the interview with the Manager on 06/10/26 at 10:05am. Refer to the interview with the Administrator on 06/10/26 at 10:25am. _____ Interview with the Resident Care Coordinator (RCC) on 06/10/26 at 10:15am revealed:	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 280	Continued From page 9 -She was not aware quarterly LHPS evaluations had not been completed. -She was aware LHPS evaluations needed to be completed quarterly. -There were several changes within facility processes which is why quarterly LHPS evaluations were not completed. -The facility's contracted pharmacy was in charge of scheduling a registered nurse (RN) to complete LHPS evaluations for the facility. -She and the Manager were responsible for ensuring the LHPS evaluations were completed. -There was no system in place to ensure LHPS evaluations were completed quarterly. -She expected all residents with tasks to have LHPS evaluations completed quarterly. Interview with the Manager on 06/10/26 at 10:05am revealed: -She was not aware quarterly LHPS evaluations had not been updated. -She was aware LHPS evaluations needed to be updated quarterly. -She and the RCC were responsible for ensuring LHPS evaluations were completed. -There was no system in place to ensure LHPS evaluations were completed quarterly. -She expected all residents with tasks to have LHPS evaluations completed quarterly. Interview with the Administrator on 06/10/26 at 10:25am revealed: -She was not aware quarterly LHPS evaluations had not been completed. -She was aware LHPS evaluations needed to be completed quarterly. -The facility's contracted pharmacy made a mistake when scheduling a RN to complete LHPS for the facility which is why the LHPS evaluations were not completed quarterly.	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 280	Continued From page 10 -The RCC and the Manager were responsible for ensuring the LHPS evaluations were completed. -She expected all residents with tasks to have LHPS evaluations completed quarterly.	D 280		
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 mealtime table service included a place setting consisting of a knife, fork, and spoon. The findings are: Observation of the lunch meal service on 06/09/26 between 12:00pm and 12:45pm revealed: -Thirty residents were present in the dining room. -The personal care aides (PCA) set the residents' meal tables and each resident received a napkin	D 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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	D 286		

with a fork and a spoon; there were no knives.
-The residents were served chicken and dumplings, lima beans, peach cobbler, and a biscuit.
-Several of the residents cut the chicken and dumplings into smaller pieces slowly with the side of their forks and spoons.

Observation of the kitchen on 06/09/26 at 12:35pm revealed there were not enough knives available for all the residents to use during meal services.

Observation of the breakfast meal service on 06/10/26 between 7:00am and 7:45am revealed:
-Thirty-one residents were present in the dining room.
-Each resident received a napkin with a fork and a spoon; there were no knives.
-The residents were served cereal, scrambled eggs, a sausage patty, grits, and toast,
-Several of the residents cut the sausage patty into smaller pieces slowly with the side of their forks and spoons.

Observation of the kitchen on 06/10/26 at 7:45am revealed there were not enough knives available for all the residents to use during meal services.

Interview with a resident on 06/10/26 at 8:05am revealed:
-The dining tables were set before she walked in for every meal.
-Every table usually was set with a non-disposable fork, spoon, and a napkin.
-She was not sure why the residents were not served with non-disposable knives.

Interview with a second resident on 06/10/26 at 8:10am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 12	D 286		

-He was provided with a non-disposable fork and spoon at every meal and usually was provided with a napkin.
-He could not recall the last time the kitchen staff provided him with a knife for the meal service but he had stopped asking.
-He was not sure why the residents were not served with non-disposable knives but he preferred to have a non-disposable fork, spoon, and knife for every meal.

Interview with the cook on 06/10/26 at 7:05am revealed:
-The PCAs usually set the tables before every meal and she was aware the PCAs did not set the residents' tables with knives.
-She was aware the residents were supposed to have a full place setting including a fork, knife and spoon, but there were some residents who should not have knives due to dementia-related reasons.

Interview with a PCA on 06/10/26 at 7:45am revealed:
-She was not aware the residents were supposed to have a full place setting including a fork, knife and spoon.
-She was aware the residents were provided with forks and spoons only for both the lunch meal service on 06/09/26 and the breakfast meal service on 06/10/26.
-She set the tables with only forks and spoons for meals services because she had been trained to set the residents' tables that way.

Interview with a second PCA on 06/10/26 at 7:55am revealed:
-She was not aware the residents were supposed to have a full place setting including a fork, knife and spoon.
-She was aware the residents were provided with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030010	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PS SENIOR LIVING OF MOCKSVILLE	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 13	D 286		

forks and spoons only for the breakfast meal service on 06/10/26.
-She set the tables with only forks and spoons for meal services because she had been trained to set the residents' tables that way.

Interview with the Resident Care Coordinator (RCC) on 06/10/26 at 8:15am revealed:
-She was aware that PCAs were not setting resident meal tables with knives due to residents with dementia-related diagnoses.
-She was aware the residents were supposed to have a full place setting including a fork, knife and spoon.

Interview with the Manager on 06/10/26 at 8:45am revealed:
-She was the interim Dietary Manager (DM) until someone was hired for the position.
-She was aware that PCAs were not setting resident meal tables with knives due to residents with dementia-related diagnoses.
-She was aware the residents were supposed to have a full place setting including a fork, knife and spoon.

Interview with the Administrator on 06/10/26 at 10:25am revealed:
-She was not aware until today (06/10/26) that PCAs were setting resident meal tables with forks and spoons only.
-She was aware the residents were supposed to have a full place setting including a fork, knife and spoon.
-She expected the PCAs and the dietary staff to ensure residents have a full place setting including a fork, knife and spoon at every meal unless documented elsewhere in a resident's care plan.