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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029011	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALLARD RIDGE ASSISTED LIVING	9420 NORTH HIGHWAY 150 CLEMMONS, NC 27012

(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 and a complaint investigation from 06/16/26 through 06/18/26.	D 000		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents' ice supply was protected from contamination as evidenced by two scoops for the ice machine in the kitchen uncovered on top of the machine. The findings are:	D 283	Removed ice scoops from top of ice machine. Cleaned and sanitized scoops and storage containers Ice scoops will be stored in designated clean, covered Contair - adjacent to ice machine.	6/22/26 6/22/2026

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE K Wellwells TITLE ED (X6) DATE 7/23/26

Reviewed and Acknowledged K.M. 07/24/26

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D 283	Continued From page 1 Initial observation of the kitchen on 06/16/26 at 11:20am revealed: -Two scoops for the ice machine were lying uncovered on top of the machine. -The covers for the two scoops were covered with dust and were lying to the far right of the top of the machine. Second observation of the kitchen on 06/17/26 at 7:24am revealed: -Two scoops for the ice machine were lying uncovered on top of the machine. -The covers for the two scoops were covered with dust and were lying to the far right of the top of the machine. -The dietary aide scooped ice from the ice machine to prepare the residents' water glasses for the morning breakfast meal. Interview with the dietary aide on 06/17/26 at 7:52am revealed: -She was not aware that the ice scoops in the kitchen must remain covered when not in use nor the reason the scoops needed to remain covered. -The ice scoops were usually kept uncovered on top of the ice machine. Interview with the cook on 06/17/26 at 7:35am revealed: -The ice scoops for the ice machine had been lying uncovered on top of the machine for more than several months. -He was not aware that the ice scoops in the kitchen must remain covered when not in use. Interview with the Dietary Manager (DM) on 06/17/26 at 8:30am revealed: -The ice machine in the kitchen serviced the entire facility.	D 283	Staff educated on proper Ice Scoop Storage and infection Control. The dining Service Director will monitor Ice Scoop Storage and cleanliness. weekly.	07/22/2026

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D 283	Continued From page 2 -She was aware that the ice scoops were uncovered on the ice machine on 06/16/26 and 06/17/26 but she was not aware that the ice scoops in the kitchen must remain covered when not in use. Telephone interview with the Administrator on 06/17/26 at 2:58pm revealed: -She was not aware that the ice scoops were uncovered on the ice machine on 06/16/26 and 06/17/26. -She was aware that the ice scoops must be stored in a cover when not in use. -She was aware of the potential for cross contamination if the ice scoops were left uncovered. -All kitchen staff were responsible for ensuring the ice scoops remained covered when not in use. -She expected the ice scoops to be stored in covered containers and not on top of the ice machine.	D 283		
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: Based on observations and interviews, the facility failed to ensure the rights of assisted living (AL) residents were maintained including being treated with dignity and respect related to being served food within the posted scheduled meal service times.	D 338		

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D 338	Continued From page 3 The findings are: Interview with a resident during the initial tour on 06/16/26 at 10:10am revealed: -Meals were usually served to residents an hour or longer after the posted mealtimes. -She had witnessed residents leaving the dining room without eating due to the meals being served long after the posted mealtime. Interview with another resident during the initial tour on 06/16/26 at 10:20am revealed: -It was not unusual for residents to wait for 50 minutes to an hour for their meals during mealtimes. -The residents had mentioned their dissatisfaction with excessive waiting times for meal service to the management of the facility through the resident council meetings, but nothing changed. Observation of the dining room at the lunch meal service on 06/16/26 at 12:05pm revealed: -There was a sign posted with a lunch service time of 12:30pm. -There were 42 residents seated in the dining room waiting to be served. -There was one kitchen staff plating food from the kitchen to a dining cart for all 42 residents. -The dietary aide and the personal care aides (PCA) served the residents from the dining cart. -The first table was served at 1:05pm and the last table was served at 1:30pm. -Several residents left the dining room before the dietary aide and PCAs served the meals to all the residents. Interview with a resident after the lunch meal service on 06/16/26 at 1:40pm revealed:	D 338	the meal service schedule was reviewed immediately with Dining Director. 7/19/2026 Dining/Cook staff educated on meal/service time. Dining staff will follow standardized meal service timeline to ensure all residents are served within reason of post times. 7/22/2026 The Dining Director will monitor meal service and verify meals begin and are served within reason of post times. 7/29/2026 The Executive Director will complete random meal service monitoring to ensure Resident rights and meals are on time. Weekly. 7/22/2026	

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D 338	Continued From page 4 -By the time she was served, half the people had already left the dining room. -She did not like having to wait for her food and it was inconvenient. -She had mentioned her concern to the PCAs at various times, but nothing changed. Interview with a second resident after the lunch meal service on 06/16/26 at 1:45pm revealed: -Dinner service took even longer because there were more residents that came to dinner. -She waited 45 minutes to an hour to be served meals at times which made her agitated. -She had mentioned it to the PCAs and to management at various times, but nothing changed. Observation of the dining room at the breakfast meal service on 06/17/26 at 7:20am revealed: -There was a sign posted with a breakfast service time of 7:30am. -There were 38 residents seated in the dining room waiting to be served. -There was one kitchen staff plating food from the kitchen to a dining cart for all 38 residents. -The dietary aide and the PCAs served the residents from the dining cart. -The first table was served at 7:55am and the last table was served at 8:25am. -Several residents left the dining room before the dietary aide and PCAs served the meals to all the residents. Interview with a resident after the breakfast meal service on 06/17/26 at 8:40am revealed: -His table was always the last to be served during the breakfast meal service and the dinner meal service. -By the time he was served, half the people had already left the dining room.	D 338		

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D 338	Continued From page 5 -He did not like having to wait for his food and he had waited anywhere from 45 minutes to an hour for his meal at times. -He stopped mentioning his concerns about mealtime delays because nothing changed. Interview with a second resident after the breakfast meal service on 06/17/26 at 8:45am revealed: -The wait time for meal service had usually been an hour following the posted mealtime for as long as he could remember being at the facility. -Dinner service took even longer because there were more residents that came to dinner. -He did not like having to wait for his food and watching other residents leave because they had finished their meal before he ever received his. Interview with a dietary aide on 06/17/26 at 8:35am revealed: -She was aware it took a long time for all the residents to be served their meals. -She was not aware residents had complained about being served food late but she served the residents' meals once the cook prepared the meal from the kitchen. Interview with the cook on 06/17/26 at 7:30am revealed: -He served the AL residents meals once all the meals were served to the residents in the special care unit (SCU). -He was aware it took a long time for all the AL residents to be served their meals but he served the resident meals according to how the Dietary Manager (DM) instructed him. -He was not aware residents had complained about being served food late. Interview with the DM on 06/17/26 at 8:30am	D 338		

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D 338	Continued From page 6 revealed: -She was aware it took a long time for all the residents to be served their meals. -She was not aware residents had complained about being served food late. Interview with a PCA on 06/17/26 at 9:05am revealed: -She was aware residents had to wait 45 minutes to an hour for their meals during the lunch meal on 06/16/26 and during the breakfast meal service on 06/17/26. -She was aware residents had complained about being served food late and had told the dietary staff and management at the facility, but no changes had been made to correct the issue for long wait times. Interview with the Resident Care Coordinator (RCC) on 06/18/26 at 11:42am revealed: -She was aware residents had to wait 45 minutes to an hour for their meals during the lunch meal on 06/16/26 but was not aware of the breakfast meal service on 06/17/26 because she had not arrived until later that day. -She was aware residents had previously complained about being served food late but no changes had been made to correct the issue for long wait times. -She expected residents to be served their meals within 20 to 30 minutes as a reasonable serving time. Interview with the Director of Clinical Services (DCS) on 06/17/26 at 9:15am revealed: -She was not aware residents had to wait 45 minutes to an hour for their meals during the lunch meal on 06/16/26 and during the breakfast meal service on 06/17/26. -She was aware residents had complained	D 338		

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D 338	Continued From page 7 previously about long wait times for meals but she was not aware the residents had complained recently. -She expected residents to be served their meals within 30 minutes as a reasonable serving time after the posted mealtime. Telephone interview with the Administrator on 06/17/26 at 2:58pm revealed: -She was not aware residents had to wait 45 minutes to an hour for their meals during the lunch meal on 06/16/26 and during the breakfast meal service on 06/17/26. -Residents had expressed concern in previous resident council meetings about long wait times for meals but she was not aware the residents had complained recently. -She expected residents to be served their meals within 30 minutes after the posted mealtime outside of the dining room.	D 338		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control measures were implemented during the morning medication pass.	D 371	Staff educated on infection control Practices during med administration. Director of Clinical Services with monitor med tech Compliance for Prevention of possible recurrence. quartley. 7/20/2026	

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D 371	Continued From page 8 The findings are: Observation of the morning medication pass on 06/17/26 between 8:02am and 8:35am revealed: -Two medication aides (MAs) administered medications to the residents. -Hand hygiene was performed before and after a resident was administered medication. -Between 8:29am and 8:36am, the second MA prepared medications for a resident. -One oral medication fell on top of the medication cart. -The MA was not wearing gloves and picked up the oral medication with her bare hand and put it into the medication cup. -The MA was not wearing gloves and picked up a medication capsule and a second oral medication with her bare hand to separate the medications from other medications that would be crushed. -The MA crushed all but the two separate oral medications, mixed the medications with vanilla pudding, and administered the medications to a resident at 8:37am. Interview with the MA observed during the medication pass on 06/17/26 at 12:38pm revealed: -She picked up the oral medication with her bare hands during the medication pass and was not wearing gloves. -She did not think about wearing gloves during the medication preparation but she thought afterward that she should have worn gloves. Interview with the Resident Care Coordinator (RCC) on 06/18/26 at 11:45am revealed: -She expected MAs to discard an oral medication that was dropped on top of the medication cart, complete a wasted medication form, and get a	D 371		

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D 371	Continued From page 9 new oral medication to administer. -MAs should not touch oral medications with their bare hands. Interview with the Director of Clinical Services (DCS) on 06/18/26 at 9:42am revealed: -She expected the MAs to get rid of an oral medication that was dropped on top of the medication cart and to get a new oral medication. -MAs should be able to use tongs that were stored on the medication carts to separate oral medications that needed to be crushed. Telephone interview with the Administrator on 06/17/26 at 3:10pm revealed: -She expected the MAs to wear gloves or use tongs so the MAs would not be touching oral medications with their bare hands. -She expected the MAs to discard any oral medication that fell on top of the medication cart and to get a new oral medication to administer to a resident.	D 371		
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 interviews and record reviews, the facility failed to report to the Health Care Personnel Registry (HCPR) within 24 hours regarding an injury of unknown origin and sperm found in a resident's urine who had Alzheimer's	D 438	* ED or designated person to report any reportable events within 24-48hr of incident on going * On 7/18/2026 state educated ED, DCS and RDO on reporting events.	

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D 438	Continued From page 10 disease and resided on the special care unit (SCU) (#4). The findings are: Review of Resident #4's FL-2 dated 04/28/26 revealed: -Diagnoses included Alzheimer's disease, dyslipidemia, osteopenia, hypothyroidism, insomnia and Raynaud's syndrome. -She was ambulatory. -She was a wanderer. Review of Resident #4's electronic progress notes revealed: -On 06/06/26 at 6:45am, staff reported bruising of Resident #4's left arm. -On 06/06/26 at 9:15am, staff reported bruising of Resident #4's right eye. -On 06/06/26 at 10:11am, staff created an incident report for Resident #4. -On 06/11/26 at 10:45pm, staff reported Resident #4 was sent to the emergency room for evaluation of altered mental status, falls, edema and cellulitis. -On 06/11/26 at 10:50pm, staff created an incident report for Resident #4. -On 06/12/26 at 5:00pm, staff reported Resident #4's responsible party (RP) called to report a hospital urinalysis revealed sperm in Resident #4's urine. Requests to review Resident #4's incident reports dated 06/06/26 and 06/11/26 were denied by the facility on 06/16/26 at 1:42pm. Interview with Resident #4's RP on 06/17/26 at 10:45am revealed: -Her last visit to the facility was on 06/06/26 after staff notified her by phone of the bruising on	D 438		

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D 438	Continued From page 11 Resident #4's arm and eye. -Staff were treating the incident as a fall but could not be sure since there were no witnesses. -During a second incident on 06/11/26, Resident #4 was sent to the emergency department (ED) for evaluation. -She met Resident #4 at the hospital on 06/11/26 and was told by a physician in the ED on 06/12/26 that sperm was found in Resident #4's urine. -She called the facility on 06/12/26 and reported the sperm in the urine to the Administrator. Interview with a personal care aide (PCA) on 06/17/26 at 9:20am revealed she did not notice any bruises on Resident #4's face or arm but noticed a bruise on Resident 4's leg at the end of May and sent a picture to the director of clinical services (DCS). Interview with a second PCA on 06/17/26 at 9:43am revealed: -She noticed bruising on Resident #4's left arm following a fall out of bed but could not recall the date. -She noticed bruising on Resident #4's face, around one eye, but could not recall which eye. -She reported the bruising on Resident #4's arm and face to the medication aide (MA) on duty. Interview with a MA on 06/17/26 at 12:00pm revealed: -Resident #4 fell 2-3 times within a few days prior to her hospitalization. -She was not the MA who noticed the bruising on Resident #4's arm and face. -She had no knowledge of sperm present in Resident #4's urine. -MAs completed incident reports after assessing residents for pain, and contacting the resident care coordinator (RCC), the provider and the RP.	D 438		

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D 438	Continued From page 12 Interview with the MA Supervisor on 06/17/26 at 12:17pm revealed: -She was not aware of Resident #4's bruising on her arm or face until 06/17/26. -She had access to incident/accident reports but only reviewed them when requested by the RCC or DCS. -She was not aware of the sperm in Resident #4's urine. Interview with the RCC on 06/18/26 at 11:50am revealed: -She was familiar with Resident #4 but not aware of the bruising on her arm and face and not aware of the sperm in her urine. -If a PCA noticed bruising, they should notify the MA who would assess the area, report the findings to the Supervisor and call the provider, the on-call manager on duty (MOD) and RP before completing an incident report. -MAs were responsible for completing incident reports for injuries of unknown origin and notifying the RPs. -RCCs were responsible for state reportable incidents, and the reports should be submitted within 24 hours. -She was unaware that injuries of unknown origin or sexual assault had to be reported to the HCPR. Interview with the Administrator on 06/17/26 at 2:58 pm revealed: -She was aware of the sperm in Resident #4's urine on 06/12/26 but was not aware of the bruising on her arm and face. -Resident #4's RP phoned the facility at 10:15am on 06/12/26 and spoke to the SCU manager first before speaking to her. -She reported the sperm in Resident #4's urine to	D 438		

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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029011	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALLARD RIDGE ASSISTED LIVING	9420 NORTH HIGHWAY 150 CLEMMONS, NC 27012

(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 438	Continued From page 13 her home office on 06/12/26 and an internal investigation was being conducted. -She did not report the sperm in Resident #4's urine to the HCPR because her home office had not instructed her to do so. -She did not report Resident #4's bruising to the HCPR because she was unaware of the incident. -She had never had anything like this happen before and was unaware that reporting must occur within 24 hours. -She was responsible for reporting to the HCPR.	D 438		