STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 the Macon County Department of Social Services conducted an annual and follow-up survey on July 14, 2026 through July 16, 2026.	D 000		
D 194	10A NCAC 13F .0608 (a)(b) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents (a) Each facility with a census of 21 or more residents shall have staff on duty to meet the needs of the residents. (b) In addition to the requirement in Paragraph (a) of this Rule, each facility with a census of 21 or more residents shall comply with the following staffing requirements: (1) On first shift and second shift, the total aide duty hours shall be at least: (A) 16 hours of aide duty for facilities with a census of 21 to 40 residents. (B) 20 hours of aide duty for facilities with a census of 41 to 50 residents. (C) 24 hours of aide duty for facilities with a census of 51 to 60 residents. (D) 28 hours of aide duty for facilities with a census of 61 to 70 residents. (E) 32 hours of aide duty for facilities with a census of 71 to 80 residents. (F) 36 hours of aide duty for facilities with a census of 81 to 90 residents. (G) 40 hours of aide duty for facilities with a census of 91 to 100 residents. (H) 44 hours of aide duty for facilities with a census of 101 to 110 residents. (I) 48 hours of aide duty for facilities with a census of 111 to 120 residents. (J) 52 hours of aide duty for facilities with a	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 194	Continued From page 1	D 194		

census of 121 to 130 residents.
(K) 56 hours of aide duty for facilities with a census of 131 to 140 residents.
(L) 60 hours of aide duty for facilities with a census of 141 to 150 residents.
(M) 64 hours of aide duty for facilities with a census of 151 to 160 residents.
(N) 68 hours of aide duty for facilities with a census of 161 to 170 residents.
(O) 72 hours of aide duty for facilities with a census of 171 to 180 residents.
(P) 76 hours of aide duty for facilities with a census of 181 to 190 residents.
(Q) 80 hours of aide duty for facilities with a census of 191 to 200 residents.
(R) 84 hours of aide duty for facilities with a census of 201 to 210 residents.
(S) 88 hours of aide duty for facilities with a census of 211 to 220 residents.
(T) 92 hours of aide duty for facilities with a census of 221 to 230 residents.
(U) 96 hours of aide duty for facilities with a census of 231 to 240 residents.
(2) On third shift, the total aide duty hours shall be at least:
(A) 8 hours of aide duty for facilities with a census of 21 to 30 residents.
(B) 16 hours of aide duty for facilities with a census of 31 to 60 residents.
(C) 24 hours of aide duty for facilities with a census of 61 to 90 residents.
(D) 32 hours of aide duty for facilities with a census of 91 to 120 residents.
(E) 40 hours of aide duty for facilities with a census of 121 to 150 residents.
(F) 48 hours of aide duty for facilities with a census of 151 to 180 residents.
(G) 56 hours of aide duty for facilities with a census of 181 to 210 residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 194	Continued From page 2 (H) 64 hours of aide duty for facilities with a census of 211 to 240 residents. (3) If the Department determines the needs of the residents at a facility are not being met by staffing requirements of Paragraph (b) of this Rule, the Department shall require the facility to employ staff to meet the needs of the residents. This Rule is not met as evidenced by: A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure adequate staffing to meet the needs of residents who resided in the facility that had three residential floors. The findings are: Review of the facility current license by the Division of Health Service Regulation effective 01/01/26 revealed the facility was licensed as an assisted living (AL) with a capacity of 26 beds. Observations during the initial tour on 07/14/26 at 9:00am revealed: -The facility had three floors accessible by an elevator and a staircase. -The main entrance to the facility was on the second floor.	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 194	Continued From page 3 -Staff offices were located on the second floor. Review of the facility's current census on 07/14/26 revealed: -There were a total of 21 residents who resided in the facility. -There were 7 residents who resided on each of the floors. Review of the facility census from April 2026 to July 2026 revealed: -The census varied from 20-23 residents. -In April 2026 there were 5 residents who resided on the first floor, 7-10 residents who resided on the second floor and 4 or 5 residents who resided on the third floor. -In May 2026 there were 5 or 6 residents who resided on the first floor, 7 or 8 residents who resided on the second floor and and 5 residents who resided on the third floor. -In June 2026 there were 5 residents who resided on the first floor, 7 or 8 residents who resided on the second floor and 7-9 residents who resided on the third floor. -In July 2026 there were 7 residents who resided on the first floor, 6 or 7 residents who resided on the second floor and and 7 or 8 residents who resided on the third floor. Review of a resident's Incident/Accident Report dated 03/25/26 at 12:02pm revealed: -The incident occurred in the resident's room on the third floor. -It was an unwitnessed fall from a loss of balance, tripped, or slipped and no injuries were noted. -Another resident's family member helped the resident up from the floor and notified staff. -The resident was unsure how she fell. -The resident's primary care provider (PCP) was	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 194	Continued From page 4 notified. Review of a resident's second Incident/Accident Report dated 05/06/26 at 2:25pm revealed: -The incident occurred in the staff bathroom on the second floor. -The resident had an unwitnessed fall and sustained bruising to her right arm. -The resident's PCP was notified at 2:45pm. -The resident's family member was notified at 2:33pm. -The Manager and the medication aide (MA) assisted the resident up to a standing position without difficulty. Review of a resident's third Incident/Accident report dated 05/22/26 at 10:30pm revealed: -The incident occurred in the resident's room on the third floor. -It was an unwitnessed fall slipping on water in her room and fell onto the floor between the television and chair and the resident's roommate called staff. -The resident was found by staff lying on her back on the wet floor and she complained of pain in her lower back, left hip, and left leg. -A MA called 911 and after emergency medical services (EMS) arrived the resident did not want to be transported to the hospital for an evaluation and was assisted into bed. -Two-hour rounds would be completed for 24 hours after the fall. -The resident's family member was notified on 05/22/26 at 11:00pm. -The resident's PCP was not notified. Review of a resident's fourth Incident/Accident report dated 05/31/26 at 4:19pm revealed: -The incident occurred in the resident's room on the third floor.	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 194	Continued From page 5	D 194		

-It was an unwitnessed fall in her room and she was found lying on the floor by a personal care aide (PCA) after the PCA heard the resident yelling for help.
-The resident's PCP was notified on 05/31/26 but there was no time documented.
-The resident's family member was notified of the fall on 05/31/26 at 6:35pm.

Review of a resident's fifth Incident/Accident report dated 06/13/26 at 8:56pm revealed:
-The incident occurred in the resident's room on the third floor.
-It was an unwitnessed fall and she was found sitting in the floor in front of a chair by a MA with no injuries noted.
-The resident refused emergency transport to be evaluated at the local emergency room (ER) on 06/13/26 at 8:56pm.
-The resident's PCP was not notified.
-The resident's family member was notified on 06/13/26 at 10:00pm.
-The Manager was notified of the fall.

Review of a resident's sixth Incident/Accident Report dated 06/14/26 at 10:51am revealed:
-The incident occurred in the resident's room on the third floor.
-It was an unwitnessed fall and she was found lying on the floor with no skin tears or bruising noted.
-The resident seemed more confused, reported to staff that she did not know where she was, two staff assisted the resident from the floor into a chair, and the resident was crying reporting her pain was a 10 on a scale of 0-10.
-Staff called the resident's family member to "check on her" before the facility sent her to the hospital and after the family member arrived and talked to the resident, the resident was okay and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 194	Continued From page 6	D 194		

not sent to the hospital.
-The resident's PCP was notified on 06/14/26 at 9:49pm.
-The resident's family member was notified on 06/14/26 at 10:52am.

Interview with the Business office Manager (BOM) on 07/15/26 at 3:30pm revealed:
-All residents who required wheelchairs for ambulation resided on the second floor.
-Residents who were independent and who used a walker or walked without assistance lived on the first and third floors.

Interview with a personal care aide (PCA) on 07/15/026 at 11:35am revealed:
-She also worked as a medication aide (MA).
-Staff were not assigned to specific floors.
-Staff constantly reminded one resident who lived on the third floor who had frequent falls to use her call light.
-If staff were not on that level, staff could not hear if a resident fell or screamed if they lived on the first or third floor.

Interview with a MA on 07/15/26 at 11:10am revealed there was usually only herself and a PCA working during the day shift and there were 3 floors where residents resided, so it was not possible to have staff on each floor.

Interview with the Manager on 07/15/26 at 3:40pm revealed:
-Staff worked one of two shifts: 7:00am-7:00pm or 7:00pm-7:00am.
-One personal care aide (PCA) and one medication aide (MA) worked each shift.
-Staff were not assigned to any particular floor.
-"In general" there was always staff on the second floor and someone floated between the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 194	Continued From page 7 first and third floor. -She thought two staff were able to supervise and provide care to residents living on three floors because they made rounds to check on residents every two hours. -Some residents used the call pendants they wore but others forgot to use them. -The owners of the facility would not want to hire and fire staff based on the changing needs of residents because that was "not profitable". -The facility was very quiet so staff heard every fall that happened. -Independent residents lived on the first and third floors and residents who needed more assistance and "eyes on" lived on the second floor. -When a resident started to decline they were relocated to the second floor. -The family agreed in July 2026 to move the resident when a room became available that had a view of the parking lot. Interview with the Administrator on 07/16/26 at 11:25am revealed: -The facility was staffed according to the state regulations. -She thought two staff providing care to 21 residents who resided on three floors was adequate because rounds were made every two hours and cameras in the facility helped her monitor if staff completed the rounds. Refer to Tag D 270 NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation). The facility failed to ensure adequate staffing to meet the needs of the residents, resulting in a resident who lived on the third floor sustaining six falls and failed to move her to the second floor where she could be monitored more closely. When she had the last fall she sustained a	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 194	Continued From page 8 fractured pelvis. This failure resulted in substantial risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on July 15, 2026 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 14, 2026.	D 194		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter;	D 259		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 259	Continued From page 9 (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure the physician signed and dated the care plan within 15 days for 2 of 3 sampled residents (Resident (#2, and #3). The findings are: 1. Review of Resident #2's current FL2 dated 11/10/25 revealed diagnoses included hypertension, anemia, spinal stenosis and glaucoma.	D 259		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 259	Continued From page 10 Interview with Resident #2 on 07/14/26 at 9:40am revealed staff helped him with dressing, bathing and transfers into and out of his wheelchair. Review of Resident #2's Resident Register revealed an admission date of 08/20/25. Review of Resident #2's care plan dated 08/21/25 revealed: -Resident #2 required supervision with ambulation, toileting, bathing, grooming, dressing and transfers. -Resident #2 was independent with eating. -Resident #2's care plan was not signed by the primary care provider (PCP). Review of Resident #2's unsigned care plan dated 01/05/26 revealed: -Resident #2 was independent with transfers, dressing, grooming, toileting, bathing and eating. -Resident #2 ambulated with a wheelchair. -Resident #2's care plan was not signed by the PCP. Refer to the interview with the RCC on 7/14/26 at 4:03pm. Refer to the interview with the Manager on 07/16/25 at 11:03am. Refer to the interview with the Administrator on 07/14/26 at 2:45pm and 07/16/26 at 10:41am. 2. Review of Resident #3's current FL2 dated 04/07/26 revealed diagnoses included hypertension, memory impairment, osteopenia (low bone density), depression and anxiety. Review of Resident #3 Resident Register dated 11/23/22 revealed her date of admission was	D 259		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 259	Continued From page 11 12/09/22. Review of Resident #3's care plan dated 06/29/2026 revealed: -She required extensive assistance with mobility, and was unable to ambulate due to a pelvic fracture. -She required extensive assistance with transferring due to her pelvic fracture. -She required assistance with dressing and morning care because of her pelvic fracture. -She required extensive assistance with personal hygiene/grooming due to her pelvic fracture. -She was unable to use the toilet at this time. -She required assistance with bathing by having a bed bath. -She needed extensive assistance with nighttime preparation due to her pelvic fracture. -Resident #3's care plan was not signed by the PCP. Refer to the interview with the RCC on 7/14/26 at 4:03pm. Refer to the interview with the Manager on 07/16/25 at 11:03am. Refer to the interview with the Administrator on 07/14/26 at 2:45pm and 07/16/26 at 10:41am. _____ Interview with the RCC on 07/14/26 at 4:03pm revealed: -The LPN completed care plans and sent them to the PCP's office to be signed. -All care plans were supposed to be signed by the PCP. -The care plans that were completed the previous week were not taken over to the PCP's office until earlier today (07/14/26). -The Registered Nurse (RN) was responsible for	D 259		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 259	Continued From page 12 getting the PCP signatures on the care plans. Interview with the Manager on 07/16/25 at 11:03am revealed: -She was responsible for taking care plans to the PCP's office so they could be signed. -Since she was responsible for ensuring care plans were signed she should have "bugged them" until it they were signed and returned. Interview with the Administrator on 07/14/26 at 2:45pm and 07/16/26 at 10:41am revealed: -The RN was responsible for completing care plans and making sure the physician's signed each care plan. -She did not realize the RN was not ensuring the care plans were signed by a physician. -Sometimes they could not get the physician to sign the care plans right away. -The RCC was responsible for keeping up with resident forms and what needed to be signed. -No one had been doing chart audits so they did not know what was incomplete in the charts. -She was ultimately responsible for checking records and making sure care plans were signed by the physician.	D 259		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 270	Continued From page 13	D 270		

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on interviews and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents (Resident #3) with multiple falls and injuries.

The findings are:

Review of Resident #3's current FL2 dated 04/07/26 revealed:
-Diagnoses included hypertension, third-degree atrioventricular block, depression, anxiety, memory impairment, and osteopenia (low bone density)..
-She was ambulatory with a walker, intermittently disoriented, continent of bowel and bladder.
-She required personal care assistance with bathing.
-Recommended level of care was documented as assisted living facility.
-Her functional limitation was documented as sight.

Review of Resident #3's Resident Register dated 11/23/22 revealed:
-Date of admission was 12/09/22.
-There was documentation Resident #3 required assistance with bathing.
-Special aids were documented as walker, eyeglasses, and dentures.
-Memory was documented as forgetful and needed reminders.

Review of Resident #3's Care Plan dated 1/29/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 270	Continued From page 14	D 270		

revealed:
-She was independent with ambulation and used a walker.
-She was independent with transfers, bathing, and bed-making.
-She was able to communicate and demonstrate understanding in words and actions.
-She used good judgement, her memory was good, and she made sound decisions.

Review of Resident #3's Care Plan dated 06/29/26 revealed:
-She required extensive assistance with mobility, transfers, dressing, and personal hygiene due to a pelvic fracture.
-She was unable to ambulate to the bathroom at this time.
-She required assistance with bed baths.

Review of Resident #3's unsigned Care Plan dated 7/10/26 revealed:
-Ambulation was documented as ambulatory with a walker and she required two-person assistance with a few steps related to a pelvic fracture.
-She had limited range of motion and strength in upper extremities.
-She was sometimes disoriented with a significant loss of memory and needed to be directed.
-She was incontinent of bowel and bladder and required extensive assistance with toileting.
-She was totally dependent with ambulation, transferring, bathing, dressing, grooming and personal hygiene.
-There was documentation Resident #3 had a fractured pelvis and required extensive help handwritten in the box marked other.

Review of Resident #3's fall risk assessment form dated 07/10/26 revealed:
-She had a total score of 20 (a total score of 10 or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 270	Continued From page 15	D 270		

above represented a high risk for falls).
-There were no fall interventions identified to decrease the risk of future falls.

Review of Resident #3's Incident/Accident Report dated 03/25/26 at 12:02pm revealed:
-The incident occurred in Resident #3's room on the third floor.
-Resident #3 had an unwitnessed fall from a loss of balance, tripped, or slipped and no injuries were noted.
-Another resident's family member helped Resident #3 up from the floor and notified staff.
-Resident #3 was unsure how she fell.
-Resident #3's primary care provider (PCP) was notified.

Review of Incident/Accident Report dated 05/06/26 at 2:25pm revealed:
-The incident occurred in the staff bathroom on the second floor.
-Resident #3 had an unwitnessed fall and sustained bruising to her right arm.
-Resident #3's PCP was notified at 2:45pm.
-Resident #3's family member was notified at 2:33pm.
-The Manager and the medication aide (MA) assisted Resident #3 up to a standing position without difficulty.

Review of Resident #3's Incident/Accident report dated 05/22/26 at 10:30pm revealed:
-The incident occurred in Resident #3's room on the third floor.
-Resident #3 had an unwitnessed fall slipping on water in her room and fell onto the floor between the television and chair and Resident #3's roommate called staff.
-Resident #3 was found by staff lying on her back on the wet floor and she complained of pain in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 270	Continued From page 16	D 270		

her lower back, left hip, and left leg.
-A MA called 911 and after emergency medical services (EMS) arrived Resident #3 did not want to be transported to the hospital for an evaluation and was assisted into bed.
-Two-hour rounds would be completed for 24 hours after the fall.
-Resident #3's family member was notified on 05/22/26 at 11:00pm.
-Resident #3's PCP was not notified.

Review of Resident #3's Incident/Accident report dated 05/31/26 at 4:19pm revealed:
-The incident occurred in Resident #3's room on the third floor.
-Resident #3 had an unwitnessed fall in her room and was found lying on the floor by a personal care aide (PCA) after the PCA heard Resident #3 yelling for help.
-Resident #3's PCP was notified on 05/31/26 but there was no time documented.
-Resident #3's family member was notified of the fall on 05/31/26 at 6:35pm.

Review of Resident #3's Incident/Accident report dated 06/13/26 at 8:56pm revealed:
-The incident occurred in Resident #3's room on the third floor.
-Resident #3 had an unwitnessed fall and was found sitting in the floor in front of a chair by a MA with no injuries noted.
-Resident #3 refused emergency transport to be evaluated at the local emergency room (ER) on 06/13/26 at 8:56pm.
-Resident #3's PCP was not notified.
-A physician communication noted that Resident #3 called staff on 06/14/26 at 4:00am and reported "she was hurting all over now".
-Resident #3's family member was notified on 06/13/26 at 10:00pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 270	Continued From page 17 -The Manager was notified of the fall. Review of Review #3's Incident/Accident Report dated 06/14/26 at 10:51am revealed: -The incident occurred in Resident #3's room on the third floor. -Resident #3 had an unwitnessed fall and was found lying on the floor with no skin tears or bruising noted. -Resident #3 seemed more confused, reported to staff that she did not know where she was, two staff assisted Resident #3 from the floor into a chair, and Resident #3 was crying reporting her pain was a 10 on a scale of 0-10. -Staff called Resident #3's family member to "check on her" before the facility sent Resident #3 to the hospital and after the family member arrived and talked to Resident #3, Resident #3 was okay and not sent to the hospital. -Resident #3's PCP was notified on 06/14/26 at 9:49pm. -Resident #3's family member was notified on 06/14/26 at 10:52am. Review of Resident #3's chart notes dated 05/01/26 through 07/16/26 revealed: -There was no documentation of fall prevention interventions or increased supervision implemented after Resident #3 fell on 03/25/26, 05/06/26, 05/22/26, 05/31/26, 06/13/26, and 06/14/26. -On 05/06/26 at 2:34pm, the Manager heard a loud noise and proceeded to check the lobby staff bathroom on the second floor where she found Resident #3 sitting on the floor and slight bruising was noted on Resident #3's right arm. -On 05/22/26 at 10:30pm, Resident #3 had an unwitnessed fall in her room when she slipped on water and complained of pain in her lower back, left hip and left leg. EMS was contacted for	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 270	Continued From page 18	D 270		

evaluation and Resident #3 refused to go to the ER for evaluation and was assisted back to her bedroom.
-On 05/31/26 at 6:19pm, Resident #3 fell in the floor and complained of pain in both her hips and right shoulder. Her vital signs were taken and the POA was contacted.
-On 06/13/26 at 8:56pm, Resident #3 had an unwitnessed fall in her room and was found by the MA with no visible marks or bruises noted and the Manager and Resident #3's family member were notified.
-On 06/14/26 at 10:50am, Resident #3 was found lying on the floor of her room, complained of terrible pain and rated the pain as a 10. The PCA took Resident #3's vital signs and the MA contacted Resident #3's family member.

Review of Resident #3's hospital ER discharge instructions dated 06/27/26 revealed:
-Reason for visit was Resident #3 complained of pain and leg swelling.
-Resident #3 had a hip/pelvic x-ray and was diagnosed with a pelvic fracture.

Review of the hospital discharge instructions dated 07/07/26 revealed:
-Resident #3 was evaluated and diagnostic results included a non-displaced U-shaped sacral fracture with transverse extension at the junction of S2 and 3 but no kyphotic deformity (type of fracture involving the lower spine and pelvis).
-A recommendation to a skilled nursing facility was made for rehabilitation.

Review of Resident #3's record revealed:
-There was no documentation of increased supervision for Resident #3 after the first fall on 03/25/26.
-There were no orders for fall prevention

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 270	Continued From page 19	D 270		

interventions ordered for Resident #3 after the first fall on 03/25/26.

Interview with Resident #3 on 07/15/26 at 3:32pm revealed:
-She had experienced several falls and complained to staff about the pain.
-She knew her last fall was "bad", but she just made herself keep moving even though she was in pain.
-She was still in terrible pain.
-Her pain was so bad she thought she was going to die when she got her family member to take her to the hospital to be evaluated.

Interview with Resident #3's family member on 07/15/26 at 3:40pm revealed:
-He had noticed that she was having a harder time getting out of her chair and that is when he thought something was wrong.
-Resident #3 woke up one morning in pain about a week after her last fall and another family member was notified.
-The other family member contacted 911 for Resident #3 to be sent to the ER to be evaluated.

Interview with a MA on 07/15/26 at 9:30am and 11:10am revealed:
-Resident #3's room was moved from the third floor down to the second floor while she was in the hospital so staff could "keep eyes on her better".
-Staff were supposed to document 2-hour rounds for 24 hours for Resident #3 after each fall.
-Staff were supposed to complete 2-hour rounds for all residents, but they did not document the rounds unless a resident had a fall and then staff documented the 2-hour rounds for 24 hours.
-She was not instructed by management to implement any fall prevention interventions or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 270	Continued From page 20	D 270		

increase supervision for Resident #3 after any of Resident #3's falls.
-A chair or bed alarm would not have worked for Resident #3 because staff would not have been able to hear it since Resident #3's room was previously located on the 3rd floor.
-There is usually only herself and a PCA working during a shift and there were 3 floors where residents reside, so it was not possible to have staff on each floor.

Interview with the Manager on 07/15/26 at 11:16am and 11:57am revealed:
-There was no fall interventions put into place after each of Resident #3's falls.
-They did not have a supervision or fall policy.
-Staff informed residents to use their call lights to get assistance and try to prevent falls.
-Resident #3's family talked with her about falls and moving her to the second floor where more staff were located and she agreed.
-Resident #3's room was moved to the second floor after they found out Resident #3 had sustained a pelvic fracture after a fall.
-There was one MA and one PCA scheduled to work each shift and the facility had residents that resided on three levels.
-The residents had call bells, but they could only be heard on the second floor.
-Staff may not hear a call bell if they are not on the second floor when a resident called.
-She did not instruct staff to increase supervision or implement any fall interventions for Resident #3 after each fall.
-Staff rounded on residents every 2 hours.

Interview with a PCA on 07/15/026 at 11:35am revealed:
-Staff constantly reminded Resident #3 to use her call light.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 270	Continued From page 21 -Resident #3's room used to be upstairs, and staff could not hear her if she did fall or scream if staff were not on that floor level. -Staff completed 2-hour rounds on all residents, but they did not document the rounds unless a resident fell. -Staff completed 2-hour rounds for 24 hours for Resident #3 and signed a rounding sheet after Resident #3 had a fall. -She was not told by management to increase the frequency of supervision for Resident #3 after any of Resident #3's falls. -Resident #3 fell on 06/14/26 and started complaining to staff about her pain about 7 days later. -On 06/27/26, Resident #3 was taken to the emergency room for treatment, evaluation and diagnosed with a pelvic fracture. -She was not told by management to do anything additional after Resident #3's falls. Interview with Resident #3's family member on 07/16/26 at 12:27pm revealed: -Resident #3 had dementia. -Resident #3 had a call button but could not remember to use it to call staff for assistance. -Resident #3 experienced a few falls over the past few months. -Resident #3's last fall on 06/14/26 was when she sustained a pelvic fracture. -She was notified of several falls, but the last fall was significant. -She took Resident #3 to the hospital on 06/27/26 for pain and the hospital diagnosed Resident #3 with a pelvic fracture and she was discharged back to the facility that night. -On 06/29/26, Resident #3 was taken back to the hospital for pain and stayed in the hospital for 7 days before being sent back to the facility. -She talked to staff about having Resident #3	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 270	Continued From page 22	D 270		

moved down to the second floor of the facility so that she could be monitored more often.
-She started to worry about Resident #3 being on the third floor and staff were not always on that floor, so the facility moved Resident #3's room to the second floor while she was hospitalized.
-Staff did not tell her they increased supervision for Resident #3 after a fall.
-Staff told her they checked on Resident #3 but did not say how often.

Telephone interview with Resident #3's PCP on 07/15/26 at 4:52pm revealed:
-He thought he was notified after each of Resident #3's falls.
-She had a pelvic fracture, stayed in the hospital for a week, and had just returned to the facility.
-The facility did not have enough staff to be able to watch Resident #3 for 24 hours per day.
-He did not recall if staff had asked him about fall prevention interventions to decrease Resident #3 risk of falls.
-Resident #3 had a mild cognitive impairment, and she was not as sharp as she used to be.
-He believed the facility needed more staff for supervision of residents and if a resident had a change in condition, they should be evaluated by the ER provider.
-Resident #3's fall causing a pelvic fracture placed Resident #3 at risk of developing blood clots, decreased mobility, pain, and during the acute phase bleeding into Resident #3's thigh.

Interview with the Administrator 07/16/26 at 10:42pm revealed:
-She was not aware of Resident #3's falls occurring on 03/25/26, 05/06/26, 05/22/26, 05/31/26, 06/13/26, and 06/14/26 because staff did not copy the Incident and Accident Reports and put them in her box.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 270	Continued From page 23 -The MAs were supposed to place the Incident/Accident reports in her box, and she would sign them and give them back to staff to file in the residents' records. -They had moved Resident #3 to the main level after her last fall on 06/14/26. -She did not know what staff should do when a resident had multiple falls. -She had the MA contact the residents' family and the PCP after a fall. -Staff completed rounds every 2 hours and the cameras help to monitor if staff completed the rounds. -The facility's policy for falls included to send the resident to the ER to be evaluated and treated after a fall with head injury or if the resident experienced pain. -She did not know why Resident #3 was not sent out to the ER sooner after she fell. -She did not know what interventions could be implemented to reduce falls. _____ The facility failed to provide supervision for Resident #3 who experienced six falls within 3 months with no fall prevention interventions or increased supervision implemented after each fall resulting in the resident sustaining a pelvic fracture which increased the risk of bleeding, developing blood clots, pain, and having decreased mobility. This failure resulted in serious physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on July 15, 2026. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 14, 2026.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 24	D 280		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (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 record reviews and interviews the facility failed to ensure 2 of 3 sampled residents (Resident #2 and #3) had a Licensed Health Professional Support (LHPS) review completed quarterly by an appropriate licensed health professional.	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 25 The findings are: 1. Review of Resident #2's current FL2 dated 11/10/25 revealed: -Diagnoses included hypertension, anemia, spinal stenosis and glaucoma. -He used a walker for ambulation. Review of Resident #1's record revealed: -Resident #2 had an order dated 11/26/25 for compression socks. -The most current LHPS review was dated 01/26/26 and included personal care tasks documented as dressing changes as needed. Refer to interview with the Manager on 07/14/26 at 2:30pm. Refer to interview with the Administrator on 07/16/26 at 10:41am. 2. Review of Resident #3's current FL2 dated 04/07/26 revealed diagnoses included hypertension, memory impairment, depression and anxiety. Review of Resident #3's record revealed: -The most current LHPS review was dated 01/20/26 and personal care tasks documented was dressing changes as needed. -There was a note attached to the LHPS documenting Resident #3 wore compression stockings. Refer to interview with the Manager on 07/14/26 at 2:30pm. Refer to interview with the Administrator on 07/16/26 at 10:41am. _____	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 26 Interview with the Manager on 07/14/26 at 2:30pm revealed she could not locate any LHPS that were completed since January 2026. Interview with the Administrator on 07/16/26 at 10:41am revealed: -The RN was responsible for completing the LHPS. -Every time she asked the RN about documents she said she completed them but could not find them. -No one did chart audits so they did not know what was incomplete in the charts. -She was ultimately responsible for checking records and making sure charts were up-to-date including the LHPS.	D 280		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to have matching therapeutic diet menus for 4 of 4 sampled residents (#1, #2, #4, #5) with physician-ordered therapeutic diets for guidance of food service	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 296	Continued From page 27	D 296		

staff related to a low concentrated sweets diet (#1 & #5) a mechanical soft diet (#2) and a gluten-free diet (#4).

The findings are:

Observation in the kitchen during initial tour on 07/14/26 at 10:04am revealed:
-There was a paper on a kitchen counter that documented resident's who had orders for therapeutic diets.
-There were no therapeutic diet menus in the kitchen for guidance of food service staff.

Review of the listing of therapeutic diets revealed:
-Two residents were documented as receiving a low concentrated sweets diet.
-One resident was documented as receiving a mechanical soft diet.
-One resident was documented as receiving a gluten-free diet.

1. Review of Resident #1's current FL2 dated 11/07/25 revealed:
-Diagnoses included congestive heart failure, myocardial infarction, diabetes mellitus type 2, hypothyroidism, neuropathy, and coronary artery disease.
-An order for a low concentrated sweets diet.

Refer to interview with the cook on 07/14/26 at 10:04am.

Refer to interview with the Business Office Manager (BOM) on 07/14/26 at 10:23am.

Refer to telephone interview with the Registered Dietitian on 07/15/26 at 10:03am.

Refer to interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 296	Continued From page 28 07/16/26 at 10:41am. 2. Review of Resident #5's current FL2 dated 06/01/26 revealed: -Diagnoses included diabetes, elevated lipids, gout, hypertension and congestive heart failure. -An order for a low concentrated sweets diet. Refer to interview with the cook on 07/14/26 at 10:04am. Refer to interview with the Business Office Manager (BOM) on 07/14/26 at 10:23am. Refer to telephone interview with the Registered Dietitian on 07/15/26 at 10:03am. Refer to interview with the Administrator on 07/16/26 at 10:41am. 3. Review of Resident # 4's unsigned, undated FL2 revealed diagnoses included chronic joint pain, hypertension, elevated lipids and colitis (inflammation of the inner lining of the large intestine. Review of Resident #4's record revealed an order dated 05/08/25 for a gluten-free diet. Interview with Resident #4 on 07/15/26 at 8:21am revealed the facility always provided a gluten-free diet. Refer to interview with the cook on 07/14/26 at 10:04am. Refer to interview with the Business Office Manager (BOM) on 07/14/26 at 10:23am. Refer to telephone interview with the Registered	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 296	Continued From page 29 Dietitian on 07/15/26 at 10:03am. Refer to interview with the Administrator on 07/16/26 at 10:41am. 4. Review of Resident #2's current FL2 dated 11/10/25 revealed diagnoses included hypertension, anemia, spinal stenosis and glaucoma. Review of Resident #2's record revealed an order dated 08/26/25 for a mechanical soft diet. Refer to interview with the cook on 07/14/26 at 10:04am. Refer to interview with the Business Office Manager (BOM) on 07/14/26 at 10:23am. Refer to telephone interview with the Registered Dietitian on 07/15/26 at 10:03am. Refer to interview with the Administrator on 07/16/26 at 10:41am. _____ Interview with the cook on 07/14/26 at 10:04am revealed: -They used the regular menu to prepare all diets. -She did not have access to therapeutic diet menus. -She knew how to adapt the regular menu to make it work for the therapeutic diet orders. -The daily menu papers that residents used to choose their meals were printed by office staff and brought to the kitchen each week. Interview with the business office manager (BOM) on 07/14/26 at 10:23am revealed: -The facility used a four-week rotation of menus that were prepared by the dietitian that worked for	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 296	Continued From page 30 the corporation. -She was responsible for printing out the daily menus and took them to the kitchen at the beginning of each week. -The kitchen used to have menus but they did not use them any more and the cook did not have any therapeutic diet extensions to reference. -The cooks "just knew" how to prepare the foods and were able to adapt the regular menu to fit the therapeutic diets. Telephone interview with a Registered Dietitian on 07/15/26 at 10:03am revealed: -She developed menus, including therapeutic diet menus for the facility about five years ago. -No one from the facility requested updates to the menus until yesterday (07/14/26). -Yesterday the BOM sent her a listing of the therapeutic diet menus they had used previously but they did not match the current resident diet orders. Interview with the Administrator on 07/16/26 at 10:41am revealed: -She did not know the residents current diet orders did not have a matching therapeutic diet menu. -She knew the cooks were not following the old menus they had used in the past. -She ultimately was responsible for ensuring the kitchen had current menus since the food service director was on leave.	D 296		
D 349	10A NCAC 13F .1002 (f) Medication Orders 10A NCAC 13F .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing	D 349		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 349	Continued From page 31	D 349		

orders and orders for self-administration are reviewed and signed by the resident's physician or prescribing practitioner at least every six months.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure all current orders for medications and treatments were reviewed and signed by the resident's primary care provider (PCP) at least every 6 months for 2 of 3 sampled residents (Resident #1 and #2).

The findings are:

1. Review of Resident #1's current FL2 dated 11/07/25 revealed diagnoses included congestive heart failure, myocardial infarction, diabetes mellitus type 2, hypothyroidism, neuropathy, and coronary artery disease.

Review of Resident #1's physician's medication orders dated 11/07/25 revealed:
-There was an order for amitriptyline (used to treat chronic nerve pain) 25 mg take 1 tablet daily at bedtime.
-There was an order for aspirin (used as a blood thinner to prevent heart attacks and strokes in high-risk individuals) 81mg chew 1 tablet daily.
-There was an order for bumetanide (used to treat fluid retention and swelling) 1mg take 1 tablet daily.
-There was an order for Dexcom (a continuous glucose monitoring device) change every 10 days.
-There was an order for Entresto (a combination medication used to treat chronic heart failure and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 349	Continued From page 32	D 349		

blood pressure) 24mg-25mg take ½ tablet twice daily.
-There was an order for gabapentin (used to treat nerve pain) 300mg take 1 capsule every morning at 8:00am.
-There was an order for gabapentin 300mg take 1 capsule every day at lunch at 12:00pm.
-There was an order for gabapentin 600mg take 1 tablet at bedtime.
-There was an order for lispro insulin (used to treat elevated blood glucose levels) inject 7 units two hours after the evening meal if the blood glucose level was greater than 180.
-There was an order for lispro insulin inject 3 units three times daily as needed for blood glucose levels greater than 180.
-There was an order for Jardiance (used to treat elevated blood glucose levels) 25mg take 1 tablet every morning.
-There was an order for lantus (a long-acting insulin used to treat elevated blood glucose levels) inject 12 units at bedtime.
-There was an order for levetiracetam (used to treat seizures) 500mg take 1 tablet twice daily.
-There was an order for levothyroxine (used to treat low thyroid levels) 100mcg take 1 tablet every day.
-There was an order for a lidocaine patch (used to treat pain) 5% apply 1 patch topically to the hip once daily and may wear up to 12 hours.
-There was an order for melatonin (used to treat sleep problems) 3mg take 2 tablets at bedtime.
-There was an order for metoprolol extended release (ER) (used to treat high blood pressure and manage heart failure) 25mg take 1 tablet daily.
-There was an order for potassium chloride ER (used to treat low potassium levels) 10meq take 1 tablet daily.
-There was an order for rosuvastatin (used to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 349	Continued From page 33	D 349		

treat elevated cholesterol levels) 40mg take 1 tablet at bedtime.
-There was an order for senokot-s (used to treat constipation) 8.5mg-50mg take 1 tablet twice daily.
-There was an order for acetaminophen (used to treat mild pain and fever) 325mg take 2 tablets twice daily as needed for pain/fever.
-There was an order for anti-diarrheal (used to treat loose stools) 2mg take 2 tablets for initial occurrence of diarrhea and take 1 tablet after each loose stool with a maximum of 4 tablets in 24 hours.
-There was an order for cranberry (a supplement used to treat a urinary tract infection) 450mg take 1 tablet every day as needed for a urinary tract infection.
-There was an order for diphenoxylate-atropine (used to treat diarrhea) 2.5-0.025mg take 1 tablet four times daily as needed for diarrhea.
-There was an order for nitroglycerin (used to relax blood vessels, treat chest pain, and reduce the heart's workload) 0.4mg place 1 tablet under the tongue every 5 minutes up to 3 doses as needed for chest pain then call the physician.
-There was an order for ondansetron (used to treat nausea and vomiting) 4mg take 1 tablet every 8 hours as needed for stomach.
-There was an order for refresh tears (used to treat dry eyes) 0.5% place 2 drops into affected eyes every 4 hours as needed for dry and itching eyes.

Review of Resident #1's record revealed there were no six-month medication orders and treatments reviewed or signed by Resident #1's physician.

A request for Resident #1's six-month signed physician's orders was made on 07/14/26 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 349	Continued From page 34	D 349		

12:20pm and was not provided by the survey exit.

Interview with the Resident Care Coordinator (RCC) on 07/14/26 at 4:30pm revealed:
-Resident #1 saw a PCP in another city.
-The facility's contracted nurse was responsible for keeping up with when the six-month physician's orders were due and taking them to the PCP's office to drop them off to be reviewed and signed.
-She thought Resident #1's six-month physician's orders were not transported to the PCP's office because Resident #1 did not see a local PCP.
-There was no staff at the facility designated to follow-up to make sure the residents' medication and treatment orders were up to date.
-She faxed Resident #1's medication orders list to Resident #1's PCP today (07/14/26) and had not received the six-month orders back yet.

Refer to the interview with the Manager on 07/15/26 at 10:15am.

Refer to the interview with the Administrator on 07/16/26 at 10:42am.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 07/14/26 at 4:26pm was unsuccessful.

2. Review of Resident #2's current FL2 dated 11/10/25 revealed diagnoses included hypertension, anemia, spinal stenosis and glaucoma.

Review of Resident #2's physician's medication orders dated 11/10/25 revealed:
-There was an order for buspirone (used to treat anxiety) 15 mg take 1 tablet twice daily.
-There was an order for Eliquis (used to treat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 349	Continued From page 35	D 349		

blood clots) 5mg take 1 tablet twice daily.
-There was an order for ferrous sulfate (used to treat anemia) 325mg take 1 tablet daily.
-There was an order for gabapentin (used to treat pain) 100mg take 1 tablet three times daily.
-There was an order for latanoprost eye drops 0.005% (used to treat glaucoma) one drop in eyes at bedtime.
-There was an order for memantine (used to treat dementia) 10mg take 1 tablet twice daily.
-There was an order for nervive dietary supplement (used to treat nerve pain) 1 tablet three times daily.
-There was an order for olanzapine(used to treat restlessness) 2.5mg take 1 tablet daily.
-There was an order for senna (used to treat constipation) 8.6mg take 1 tablet at bedtime.
-There was an order for tamsulosin (used for prostate health) 0.4mg take 2 capsules daily.
-There was an order for Therems (a vitamin supplement) take 1 tablet daily.
-There was an order for ultimate colon care (used to treat constipation) take 1 tablet daily.
-There was an order for vitamin C (a dietary supplement) 500mg take 1 tablet daily.
-There was an order for Vitamin D3 (a dietary supplement) 400 units take 1 tablet daily.
-There was an order for tramadol (used to treat pain) 50 mg take 1 tablet daily as needed.
-There was an order for (used to treat) mg take 1 tablet twice daily.
-There was an order for (used to treat) mg take 1 tablet twice daily.

Review of Resident #2's record revealed there were no six-month medication orders and treatments reviewed or signed by Resident #2's physician.

Interview with the Manager on 07/14/26 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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 349	Continued From page 36 2:30pm revealed she could not locate any six-month medication orders and treatments reviewed or signed by Resident #2's physician since the one signed on 11/10/25. Refer to the interview with the Manager on 07/15/26 at 10:15am. Refer to the interview with the Administrator on 07/16/26 at 10:42am. _____ Interview with the Manager on 07/15/26 at 10:15am revealed: -The facility's contracted registered nurse (RN) was responsible for keeping up with when residents needed new six-month physician's orders reviewed and signed. -She knew management failed to follow up and made sure six-month orders were completed for residents. -A new RN was hired on 07/13/26 but she did not have time to review the resident records yet to see what needed updating. Interview with the Administrator on 07/16/26 at 10:42am revealed: -She was not aware the six-month physician's orders were not up to date in the residents' records. -The former RN was responsible for reviewing resident records and made sure they were up to date. -She would have discovered the six-month physician's orders were not reviewed and signed by PCPs if she had completed chart audits, but she had some health issues and was out of work for about 6 weeks and returned to work approximately 2 weeks ago. -She "trusted it was all being done" while she was on leave.	D 349		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(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