

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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	D 000		
	The Adult Care Licensure Section conducted an annual survey on 06/08/26 and 06/09/26.			
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 exit doors had a continuously sounding device which was operational and audible throughout the facility and were accessible to two residents (#1 and #4) who were intermittently disoriented and a resident who was diagnosed with dementia (#3). The findings are:	D 067	Upon completion of the survey, the Administrator immediately addressed the deficiency by replacing and reprogramming the exit door alarm system to ensure all three exterior exit doors are equipped with continuously sounding alarms that remain activated until manually reset by staff. Each alarm was tested to verify it functioned properly and was audible throughout the facility, including the staff sleeping area. Corrective Action for Residents The Administrator reviewed the records and care plans of all residents to identify those who required additional supervision due to dementia, intermittent disorientation, wandering, or exit-seeking behaviors. Care plans were reviewed and updated as needed to reflect each resident's supervision needs. Until the alarm system was fully operational, staff increased monitoring of all exterior exits and provided additional supervision to residents at risk for unsafe exiting. Systemic Changes All direct care staff received education regarding the requirements for continuously sounding exit door alarms, responding immediately to alarm activations, monitoring residents who may become disoriented or wander, ensuring exit doors are never propped open, and promptly reporting any equipment malfunction to the Administrator. Exit door alarm testing was added to the facility's preventive maintenance program, and routine documentation of alarm testing was implemented. Monitoring The Administrator or designee will test and document the operation of each exit door alarm weekly for 90 days to verify the alarms activate properly, sound continuously until manually reset, and remain audible throughout the facility. After the initial 90-day monitoring period, alarm testing will be completed monthly as part of the facility's ongoing Quality Assurance program. Any identified deficiencies will be corrected immediately, and additional staff education will be provided as needed. Completion Date: 07/10/2026	7/10/2026

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

6T1L11

TITLE

(X6) DATE

If continuation sheet 1 of 71

Reviewed and acknowledged. SG 7/31/26

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 067	Continued From page 1 Observation of the front exit door on 06/08/26 at various times between 8:45am to 3:00pm revealed: -The front door led to the driveway which was next to a country road. -There was an audible chime that sounded 6 times when the front door was opened but stopped before the self-closing door was closed. -The audible chime could be heard throughout the building when residents entered or exited the front door. -There were no staff supervising the residents who came in and out of the door. Observation of the back exit door on 06/08/26 at various times between 9:30am and 3:00pm revealed: -The back door led to the yard. -There was an audible chime that sounded 6 times when the back door was opened but stopped before the self-closing door was closed. -The audible chime could be heard throughout the building when the door was opened. -No residents or staff were observed entering or exiting the back door. Observation of the living room exit door on 06/08/26 between 2:00pm and 4:00pm revealed: -In the living room there was an exit door leading to a porch and yard. -Residents were going in and out of the front door and the door would chime 6 times then stop. -The door was left open and there was no audible alarm. 1. Review of Resident #1's current FL-2 dated 03/19/26 revealed: -She was intermittently disoriented. -She was ambulatory.	D 067			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 067	Continued From page 2 Review of Resident #1's Resident Register revealed: -Resident #1's admission date was 07/11/25. -Resident #1's memory was adequate. Review of Resident #1's care plan dated 01/05/26 revealed she required limited staff assistance with ambulation and transfers. Observation of Resident #1 at various times on 06/08/26 between 8:45am and 4:00pm revealed: -Resident #1 ambulated in the facility without assistance. -Resident #1 exited the front door and sat in a chair on the front porch. -There were no staff supervising the residents on the front porch. Interview with Resident #1 on 06/08/26 at 3:00pm revealed: -She was independent with ambulation and transfers. -She went to a day program three days a week. -She would go outside and sit on the porch some afternoons. Attempted interview with Resident #1's Primary Care Provider (PCP) on 06/09/26 at 2:33pm was unsuccessful. Refer to the interview with a medication aide (MA) on 06/08/26 at 1:06pm. Refer to the interview with a second MA on 06/08/26 at 1:40pm. Refer to the interview with the Administrator on 06/08/26 at 11:48am. 2. Review of Resident #3's current FL-2 dated	D 067		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 067	Continued From page 3 03/19/26 revealed: -Diagnoses included dementia, schizoaffective bipolar, and mild intellectual disability. -His orientation status was marked not applicable (NA). -He was ambulatory. -He wandered. Review of Resident #3's care plan dated 01/05/26 revealed: -He required limited staff assistance with ambulation and transfers. -He was forgetful and needed reminders. -His orientation status was blank. Observation of Resident #3 on 06/09/26 from 7:52am to 8:05am revealed: -He was ambulating in the facility without assistance. -He was sitting on the front porch with 5 other residents. Interview with Resident #3 on 06/09/26 at 8:05am revealed: -He ambulated in and out of the facility as he wanted. -He walked to the sister facility which was about one mile down the road. -He would go outside at night and smoke cigarettes after the medication aide (MA) had locked the door for the night. Interview with a MA on 06/09/26 at 10:12am revealed: -She locked the facility doors around 9:00pm each night she worked. -She slept in the staff quarters but would get up a few times at night to check on the residents. -Several nights ago, when she woke up to check on the residents, she saw the front door propped	D 067			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 067	Continued From page 4 open and saw several residents outside smoking; she thought it was around midnight. -Resident #3 was one of the residents outside smoking. -She told Resident #3 and the other residents he was not supposed to be outside and to come back into the facility. -There was an audible sounding alarm when the front exit door opened but it could not be heard in the staff quarters when she was asleep. Attempted interview with Resident #3's Primary Care Provider (PCP) on 06/09/26 at 2:33pm was unsuccessful. Refer to the interview with a MA on 06/08/26 at 1:06pm. Refer to the interview with a second MA on 06/08/26 at 1:40pm. Refer to the interview with the Administrator on 06/08/26 at 11:48am. 3. Review of Resident #4's current FL-2 dated 03/19/26 revealed: -There was a diagnosis of intellectual disabilities. -He was intermittently disoriented. -He was ambulatory. Review of Resident #4's care plan dated 01/05/26 revealed: -He required limited staff assistance with ambulation and transfers. -He was oriented and his memory was adequate. Observation of Resident #4 at various times on 06/08/26 from 8:45am to 4:00pm revealed: -He ambulated in the facility without assistance. -He ambulated outside multiple times during the	D 067			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 067	Continued From page 5 day and sat under the gazebo. -There was an audible sounding alarm when the front exit door was opened, but there was no supervising staff that observed the front exit door when the alarm sounded. Based on observation, record reviews, and interviews it was determined that Resident #4 was not interviewable. Attempted interview with Resident #4's Primary Care Provider (PCP) on 06/09/26 at 2:33pm was unsuccessful. Refer to the interview with a medication aide (MA) on 06/08/26 at 1:06pm. Refer to the interview with a second MA on 06/08/26 at 1:40pm. Refer to the interview with the Administrator on 06/08/26 at 11:48am. Interview with a MA on 06/08/26 at 1:06pm revealed: -The facility had three exit doors, and all three doors had audible alarms. -The door alarms were not continuous. -The residents went in and out of the exit doors as they wanted. -The residents would walk to the sister facility a mile down the road, but they always came back. -She did not check to see who went in and out of the doors when the alarms went off. Interview with a second MA on 06/08/26 at 1:40pm revealed: -The exit doors had an audible sounding alarm on them that could be heard throughout the facility when the doors were opened.	D 067		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 067	Continued From page 6 -The audible sounding alarm would stop within a few seconds. -She did not have to silence the alarm. -She did not check the doors when the alarm sounded. -The residents were in and out of the facility most of the day. -Some of the residents walked to the sister facility which was about a mile down the road. -The residents did not tell the staff when they were going to the sister facility. Interview with the Administrator on 06/08/26 at 11:48am revealed: -There were audible alarms on the exit doors. -He did not know the alarms were to be continuous until silenced by staff. -He had never seen the doors propped open when he visited. -He was concerned that the doors were being propped open at night but the concerns were not voiced. -He did not have residents who wanderer in the facility. -He did not have any residents who were disoriented in the facility. -If intermittently disoriented was checked on the FL-2, it was incorrect. -He would speak with the Primary Care Provider about correcting the FL-2s.	D 067			
D 074	10A NCAC 13F .0306 (a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor	D 074			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 074	Continued From page 7 coverings that are clean, safe, and functional; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the floors, windows, and blinds were kept clean in the living room, dining room, and residents' rooms. The findings are: Observation of the dining room on 06/08/26 at 9:00am revealed: -There were no residents in the dining room. -The table had not been wiped and had food crumbs on it. -The dining room floor was dirty with food crumbs and dirt on the floor. -The window seal was dirty and needed to be wiped down. -The blinds were dirty with visible dust. Observation of the living room on 06/08/26 at 10:00am revealed: -The floors were dirty and in need of sweeping and mopping.	D 074	Following the survey, housekeeping staff completed a comprehensive cleaning of the entire facility. Resident bedrooms, bathrooms, the dining room, living room, and all common areas were cleaned. Floors were swept and mopped, dining tables were cleaned and sanitized, and window sills, blinds, baseboards, furniture, entry mats, and other identified surfaces were cleaned. Dust, debris, food residue, and insects observed during the survey were removed to ensure the environment was clean, safe, and functional. Corrective Action for Residents The Administrator conducted a facility-wide inspection of all resident rooms and common areas to identify any additional housekeeping concerns. Any deficiencies noted during the inspection were corrected immediately. Residents continue to be encouraged to participate in light housekeeping activities if they choose and are able; however, facility staff remain responsible for maintaining all resident rooms and common areas in accordance with state regulations. Systemic Changes A written housekeeping schedule was developed and implemented outlining daily, weekly, and monthly cleaning responsibilities. Cleaning assignments were reviewed with all direct care and housekeeping staff to ensure expectations were clearly understood. Staff received education regarding environmental sanitation, infection prevention, documentation of completed cleaning tasks, and the importance of reporting maintenance or housekeeping concerns promptly to the Administrator. Monitoring The Administrator or designee will complete and document weekly environmental inspections for 90 days to ensure resident rooms and common areas remain clean, safe, and well maintained. Inspections will include floors, furniture, windows, window sills, blinds, baseboards, dining areas, bathrooms, and other high-use areas. After the initial 90-day monitoring period, inspections will be conducted monthly as part of the facility's ongoing Quality Assurance program. Any deficiencies identified will be corrected promptly, and additional staff education will be provided when indicated. Completion Date: 06/20/2026	6/20/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 074	Continued From page 8 -The baseboards were dirty with a buildup of dirt along the baseboards and corners. -There were dead bugs on the floors and dirt under the tables. -There was a build up of dirt on the blinds and the window seals. -The entry mat at the living room door was dirty with trash and leaves. Observation of a resident's room on 06/09/26 at 7:30am revealed: -The floors were dirty and in need of sweeping and mopping. -There was dust on the top of the chest of drawers. -There was a buildup of dirt on the window blinds and the corners of the floors. Observation of another resident's room on 06/09/26 at 7:45am revealed: -The floor was dirty and in need of sweeping and mopping. -There was a dead moth, a dead grasshopper and several small bugs noted on the floor. -The window seals were dirty and there was a buildup of dirt on the blinds. -The windows were dirty and had a buildup of dirt between the windows and window screens. Interview with a resident on 06/09/26 at 7:05am revealed: -She and her roommate were responsible for cleaning their rooms. -She swept the bedroom floors and dusted when needed. -She did not wipe down the window seals, blinds, or baseboards. Interview with a second resident on 06/09/26 at 7:15am revealed:	D 074			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 074	Continued From page 9 -He swept and mopped his room occasionally. -He mopped more than he swept his room. -He did not have a schedule for sweeping and mopping his room. -He was the only one who swept and mopped the bedroom. -His roommate did not sweep or mop the bedroom. -He did not dust or do any other cleaning except sweeping and mopping. -He did not think anyone else dusted in his room. Interview with a third resident on 06/09/26 at 7:30am revealed: -He would sweep and mop his bedroom floors every 2 weeks. -He did not dust his room. -The medication aide (MA) would help him sweep his floor sometimes. -He did not clean the blinds on the windows in his room. Interview with a MA on 06/08/26 at 1:06pm revealed: -There was no schedule for cleaning the facility. -She cleaned when she had time. -She would sweep, mop, clean the bathrooms, and anything else that needed to be done. -She cleaned the bathrooms and mopped the bathroom floors and the hall that morning. Interview with the same MA on 06/09/26 at 10:12am revealed: -The residents sweep and mop their bedrooms because they wanted too. -If the residents did not sweep and mop their bedrooms, she would. -She had not cleaned a resident's room since last Thursday.	D 074			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 074	Continued From page 10 Interview with the second MA on 06/09/26 at 12:24pm revealed: -There was no schedule for cleaning the facility. -She thought cleaning should be done daily. -She did not clean from 5:00pm to 8:00am. Interview with the Administrator on 06/09/26 at 1:25pm revealed: -The staff should have a cleaning schedule. -He was not aware that the residents were sweeping and mopping their bedroom floors. -He did not look at the windows, window seals, or blinds when he checked the rooms on his visits. -He was not aware the window seals and blinds needed cleaning.	D 074		
D 118	10A NCAC 13F .0311 (i) Other Requirements 10A NCAC 13F .0311 Other Requirements (i) In licensed facilities without live-in staff, there shall be an electrically operated call system meeting the following requirements: (1) the call system shall connect residents' bedrooms and bathrooms to a location accessible to staff; (2) residents' bedrooms shall have a resident call system activator at the resident's bed; (3) the resident call system activator shall be within reach of a resident lying on the bed; (4) the resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at point of origin; and (5) when activated, the call system shall activate an audible and visual signal in a location accessible to staff.	D 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 118	Continued From page 11 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the electrical call bell system in the facility was maintained in an operating condition. The findings are: Observation of the call bell system on 06/08/26 at 1:15pm revealed: -There were 6 resident rooms that could hold 2 residents in each room. -The call bells were a light switch on the wall two to three feet above the head of the bed. -Some of the call bells had a chain attached to the light switch; when the chain was pulled, it should activate the call bell. -The resident would have to flip the light switch if there was no chain attached. -There was a bell in the staff's quarters that should ring when the chain was pulled or the light switch was flipped. -Five of the 12 call bells did not have a chain to pull to activate the call bell. -Twelve of 12 call bells were activated and failed to ring in the staff's quarters. Interview with a resident on 06/09/26 at 7:05am revealed: -The call bells in her bedroom did not work. -She did not know how long it had been since they worked. -If she needed anything she would find the staff and tell them what she needed. Interview with a second resident on 06/09/26 at 7:15am revealed:	D 118	Following the survey, each resident was provided with an individual hand bell to use while the electrical call system was being repaired. Staff were instructed to ensure the hand bell remained within each resident's reach at all times and to increase resident rounds to monitor for needs and provide prompt assistance. Corrective Action for Residents The Administrator conducted a facility-wide inspection of all resident call stations and identified missing pull chains and system malfunctions. Missing pull chains were replaced, and arrangements were made for a qualified electrician to evaluate the system. Until repairs were completed, staff responded immediately to all hand bell requests and maintained increased supervision to ensure residents could obtain assistance at any time. Systemic Changes A licensed electrician evaluated the resident call system and determined that reprogramming and repairs were necessary to restore full operation. Repairs were scheduled for completion by August 20, 2026. Once completed, the Administrator will verify that each resident call station functions properly, is accessible from the resident's bed, activates with a single action, remains activated until manually reset by staff, and produces both an audible and visual signal in a location accessible to staff. All direct care staff received education regarding resident call system requirements, proper placement of call devices, temporary hand bell procedures, prompt response expectations, and the requirement to immediately report any equipment malfunction to the Administrator. Monitoring The Administrator or designee will document daily checks of the temporary hand bells until the electrical call system is fully operational. After repairs are completed, each resident call station will be tested and documented weekly for 90 days to verify proper operation. Following the initial monitoring period, the call system will be tested monthly as part of the facility's preventive maintenance and Quality Assurance program. Any malfunction identified will be corrected immediately, and temporary call devices will be provided until repairs are completed. Completion Date: 08/20/2026	8/20/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 118	Continued From page 12 -He did not know how long it had been since the call bells worked. -He did not use the call bell. -He would go to the medication aide (MA) and tell her what he wanted. -If there was an emergency in the building and the MA was not close by he would find her. Interview with a third resident on 06/09/26 at 7:30am revealed: -He knew the call bells did not work. -They had not worked in a long time. -He did not need the call bells. Interview with a MA on 06/08/26 at 1:06pm revealed: -The call bell system had not worked in quite a while. -She did not know how long it had been broken. -When the call bell system worked, the residents could pull the chain or flip the light switch, and the call bell system would ring in the staff's quarters. -The residents would let her know if they needed anything. Interview with a second MA on 06/08/26 at 1:40pm revealed: -She worked from 5:00pm to 8:00am everyday unless she requested off. -The call bells had not worked since she started working at the facility three months ago. -If the residents needed something, they would let her know. Telephone interview with the Supervisor on 06/09/26 at 2:45pm revealed: -She was not aware the call bells were not working. -No one had informed her the call bells were not working.	D 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 118	Continued From page 13 Interview with the Administrator on 06/09/26 at 1:25pm revealed he did not know how long the call bells had not worked.	D 118		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 sampled medications aides (MA) (Staff A and Staff B) completed a Clinical Skills Competency Validation Checklist prior to administering medications. The findings are: 1. Review of Staff A's personnel record revealed: -She was hired in 2018 and worked as a MA. -There was a certificate that she had successfully completed the 15-hour training course; the certificate was signed by a family nurse practitioner and dated 05/11/22. -There was documentation she passed the	D 125	Following the survey, Staff A and Staff B were immediately removed from medication administration duties requiring clinical skills validation until all required competency requirements were completed. Staff A successfully completed the required Clinical Skills Competency Validation Checklist. Staff B completed the Clinical Skills Competency Validation Checklist, including validation of insulin administration competency, before resuming medication administration responsibilities. Corrective Action for Residents The Administrator conducted a facility-wide review of all medication aide personnel files to verify that staff responsible for medication administration had completed the required medication training, written examination, clinical skills competency validation, and insulin competency validation, when applicable. Any missing documentation or training requirements were addressed immediately. Systemic Changes A Medication Aide Credential Verification Checklist was implemented to verify that all required education, competency validations, and supporting documentation are completed before medication administration responsibilities are assigned. The Administrator and LHPS Nurse provided documented education to medication staff regarding qualification requirements, competency validation, delegated nursing tasks, insulin administration, infection control, and documentation. Monitoring The Administrator or designee will audit medication aide personnel files monthly for 12 months. All newly hired medication staff will have qualifications verified before independently administering medications. Deficiencies will be corrected immediately, with additional education or competency validation as needed. Completion Date: 07/24/2026	7/24/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 125	Continued From page 14 written MA examination on 12/19/08. -There was no documentation Staff A had a completed Clinical Skills Competency Validation Checklist. Review of residents' April 2026 medication administration records (MAR) revealed there was documentation Staff A administered medication 30 days from 04/01/26 to 04/30/26. Review of residents' May 2026 MARs revealed there was documentation Staff A administered medication 31 days from 05/01/26 to 05/31/26. Review of residents' June 2026 MARs from 06/01/26 to 06/01/08 revealed there was documentation Staff A administered medication 8 days from 06/01/26 to 06/08/26. Interview with Staff A on 06/09/26 at 8:46am revealed: -She was trained as a MA a long time ago. -She started working in facilities and passing medications in the 1970s. -She was hired for the first time in 2018 but had left and came back to the facility several times to work. -She had worked for the facility for 3 months. -She thought a nurse completed a medication clinical checklist for her but she could not remember the name of the nurse or when the checklist was completed. Refer to the telephone interview with the Licensed Health Professional Support (LHPS) nurse on 06/09/26 at 11:00am. Refer to the interview with the Administrator on 06/09/26 at 1:49pm.	D 125			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 125	Continued From page 15 2. Review of Staff B's personnel record revealed: -She was hired in 1985 and worked as a MA. -There was a certificate that she had successfully completed the 15-hour training course; the certificate was signed by a family nurse practitioner and dated 03/20/21. -There was documentation she passed the written MA examination on 10/23/00. -There was documentation Staff B had a Clinical Skills Competency Validation Checklist but she was not checked off to administer insulin injections. Review of resident's April 2026, May 2026, and June 2026 from 06/01/26 to 06/08/26 medication administration records (MAR) revealed there was no documentation Staff B administered medications. Interview with Staff B on 06/09/26 at 8:59am revealed: -She had worked in the facility since 1985 when the facility was owned by someone else. -She continued to work for the facility even when the facility was bought by someone else. -The current owners had owned the facility for about 4 years. -She administered medications to the residents in the facility. -The previous owner showed her how to administer insulin injections in 1985 when she started working. Refer to the telephone interview with the Licensed Health Professional Support (LHPS) nurse on 06/09/26 at 11:00am. Refer to the interview with the Administrator on 06/09/26 at 1:49pm.	D 125			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 125	Continued From page 16 [Refer to Tag 358 10A NCAC 13F .1004a Medication Administration (Type B Violation)] [Refer to Tag 366 10A NCAC 13F .1004i Medication Administration (Type B Violation)] [Refer to Tag 367 10A NCAC 13F .1004j Medication Administration (Type B Violation)] [Refer to Tag 371 10A NCAC 13F .1004n Medication Administration (Type B Violation)] Telephone interview with the Licensed Health Professional Support (LHPS) nurse on 06/09/26 at 11:00am revealed she had not taught the MA class or completed a checklist for Staff A or Staff B. Interview with the Administrator on 06/09/26 at 1:49pm revealed all MAs had a Clinical Skills Competency Validations Checklist completed. The facility failed to ensure two medication aides (MA) Staff A and Staff B completed a Clinical Skills Competency Validation Checklist prior to administering medications placing the residents at risk for medication errors during medication administration and with documentation on the MARs, and infection control protocol. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/09/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 24, 2026.	D 125			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 188	10A NCAC 13F .0606 (a)(b)(c) Staffing For Facilities With A Census Of 7 to 10A NCAC 13F .0606 Staffing for Facilitites With A Census of Seven to Twelve Residents (a) In a facility with a census of greater than six but less than 13 residents, there shall be an administrator or manager in the facility or within 500 feet of the facility with a means of two-way telecommunication at all times. (b) When the administrator or manager is not on-duty, there shall be at least one staff member on-duty on the first and second shifts and at least one staff member available within the building, who need not be on-duty, on third shift. There shall be a call system connecting the bedroom of the available staff member, who may be asleep on the third shift, with each resident's bedroom. If there are residents in the facility who are disoriented or known to have wandering behavior, there shall be at least one staff member on-duty and awake at all times. (c) When the administrator or manager is on duty on the first or second shifts and available within the facility on third shift, another staff member (i.e., co administrator, manager or aide) shall be in the building or within 500 feet of the facility with a means of two-way telecommunication at all times.	D 188	Following the survey, the Administrator reviewed staffing practices to ensure adequate coverage was maintained at all times. Staffing assignments were revised to ensure a staff member is awake, alert, and available to supervise and assist residents whenever required. Overnight staff were instructed that sleeping while responsible for resident supervision is prohibited. Corrective Action for Residents The Administrator reviewed resident assessments, FL-2 forms, and care plans to identify residents requiring increased supervision due to cognitive impairment, disorientation, wandering, or other safety concerns. Care plans were updated as needed, and additional supervisory rounds were conducted during implementation. Systemic Changes The facility implemented a standardized overnight staffing and resident rounding procedure requiring documented safety rounds at least hourly. Staff received education regarding resident supervision, overnight monitoring, exit-door monitoring, documentation, and reporting changes in condition or supervision needs. Staffing schedules are routinely reviewed based on resident acuity. Monitoring The Administrator or designee will review staffing schedules, overnight assignment sheets, and resident rounding logs weekly for 90 days. Thereafter, staffing and supervision practices will be reviewed monthly through the Quality Assurance program. Deficiencies will be addressed immediately. Completion Date: 06/23/2026		6/23/2026

Division of Health Service Regulation
STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 188	Continued From page 19 -Resident #1 ambulated in the facility without assistance. -Resident #1 exited the front door and sat in a chair on the front porch. -Resident #1 got out of and back in bed independently. -Resident #1 stood from a seated position in a recliner independently. Interview with Resident #1 on 06/08/26 at 3:00pm revealed: -She was independent with ambulation, transfers, toileting, dressing, and bathing. -She went to a day program three days a week. -She would go outside and sit on the porch some afternoons. -She did not need any assistance at night; she stayed in her bed or went to the bathroom. -She knew to wake the staff up at night if needed, but she did not have to. Interview with a medication aide (MA) on 06/09/26 at 10:12am revealed: -Resident #1 did not need assistance with ambulating, transfers, toileting or dressing. -She would assist Resident #1 with her shower when she needed assistance. -Resident #1 knew to wake up the staff at night if she needed something during the night. Refer to the interview with a MA on 06/09/26 at 10:12am. Refer to the interview with a second MA on 06/08/26 at 1:40pm. Refer to the telephone interview with the Supervisor on 06/09/26 at 2:45pm. Refer to the interview with the Administrator on	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 188	Continued From page 20 06/09/26 at 1:25pm. 2. Review of Resident #3's current FL-2 dated 03/19/26 revealed: -Diagnoses included dementia, schizoaffective bipolar, and mild intellectual disability. -His orientation status was marked not applicable (NA). -He was ambulatory. -He was continent of bowels and bladder. Review of Resident #3's care plan dated 01/05/26 revealed: -He required staff supervision with toileting. -He required limited staff assistance with ambulation, transfers, grooming and dressing. Observation of Resident #3 on 06/09/26 from 7:52am to 8:05am revealed: -He was ambulating in the facility without assistance. -He was sitting on the front porch with 5 other residents. Interview with Resident #3 on 06/09/26 at 8:05am revealed: -He ambulated in and out of the facility as he wanted. -He walked down to the sister facility which was about one mile away. -He would go outside at night and smoke cigarettes. -He knew where the staff slept at night in case he needed them. -He did not have to wake the staff up for assistance at night. Interview with a medication aide (MA) on 06/09/26 at 10:12am revealed: -She locked the facility doors around 9:00pm	D 188			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 188	Continued From page 21 each night she worked. -She slept in the staff quarters but would get up a few times at night to check on the residents. -Several nights ago, when she woke up to check on the residents, she saw the front door propped open and saw several residents outside smoking; she thought it was around midnight. -Resident #3 was one of the residents outside smoking. -She told Resident #3 and the other residents he was not supposed to be outside and to come back into the facility. Refer to the interview with a MA on 06/09/26 at 10:12am. Refer to the interview with a second MA on 06/08/26 at 1:40pm. Refer to the telephone interview with the Supervisor on 06/09/26 at 2:45pm. Refer to the interview with the Administrator on 06/09/26 at 1:25pm. 3. Review of Resident #4's current FL-2 dated 03/19/26 revealed: -There was a diagnosis of intellectual disabilities. -He was intermittently disoriented. -He was ambulatory. -He had bladder incontinence and was continent of bowels. Review of Resident #4's care plan dated 01/05/26 revealed: -He required staff supervision with toileting. -He required limited staff assistance with ambulation, transfers, grooming and dressing. Observations of Resident #4 on 06/09/26 from	D 188			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 188	Continued From page 22 7:52am to 8:05am revealed: -He ambulated in the facility without assistance. -He toileted himself independently. -He ambulated outside and sat under the gazebo during the day. Based on observations, interviews, and record reviews it was determined that Resident #4 was not interviewable. Refer to the interview with a medication aide (MA) on 06/09/26 at 10:12am. Refer to the interview with a second MA on 06/08/26 at 1:40pm. Refer to the telephone interview with the Supervisor on 06/09/26 at 2:45pm. Refer to the interview with the Administrator on 06/09/26 at 1:25pm. Interview with a MA on 06/09/26 at 10:12am revealed: -She worked Monday 06/01/26 at 8:00am through Thursday 06/04/26 at 5:00pm because the other MA was on vacation. -She slept in the staff quarters from 10:00pm to 6:30am. -She was up and down during the night checking on the residents. -She locked the doors at 9:00pm. -Several nights ago, she saw the front door propped open and saw several residents outside smoking. -The residents received 5 cigarettes in the morning and 5 in the afternoon. -Some of the residents saved their cigarettes until after 9pm. -She could not hear the door alarm when she was	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 188	Continued From page 23 in the staff quarters. Interview with a second MA on 06/08/26 at 1:40pm revealed: -She worked from 5:00pm to 8:00am every day unless she requested time off. -She slept 6 to 7 hours each night in the staff quarters. -If the residents needed something during the night, they would knock on the door of the staff quarters and wake her up. -If a resident needed her and could not come to the staff quarters, their roommate would come get her. Telephone interview with the Supervisor on 06/09/26 at 2:45pm revealed the MAs should wake up every hour and check on the residents. Interview with the Administrator on 06/09/26 at 1:25pm revealed: -If the staff was sleeping, they should get up every hour and check on the residents. -He did not know residents were smoking at night and leaving the door propped open after the MA had locked the doors for the night.	D 188		
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	D 280		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a licensed health professional support (LHPS) evaluation was completed within 30 days and quarterly thereafter for 1 of 3 sampled residents (#1) who had an order for fingerstick blood sugar (FSBS) checks and insulin injection. The findings are: Review of Resident #1's current FL-2 dated 03/19/26 revealed: -There was a diagnosis of diabetes mellitus type 1. -There was an order to check FSBS three times daily. -There was an order for Novolog insulin 4 units (a fast-acting insulin used to control high blood sugars) three times daily with meals. -There was an order for Lantus insulin 30 units (a long-acting insulin used to control high blood	D 280	Following the survey, the Administrator reviewed the records of all residents receiving LHPS services to ensure required assessments, delegated nursing tasks, physician orders, and care plans were current and accurate. Missing or outdated documentation was obtained and care plans were updated as appropriate. Corrective Action for Residents A facility-wide audit was completed for all residents receiving delegated nursing services, including blood glucose monitoring, insulin administration, treatments, and other LHPS tasks. Current physician orders, LHPS assessments, and delegated nursing instructions were verified and incorporated into plans of care. Systemic Changes The facility implemented an LHPS tracking system for initial assessments, quarterly reassessments, delegated tasks, physician orders, and due dates. The Administrator established a process to notify the LHPS Nurse of new orders or changes in condition. Staff received education regarding delegated tasks, current orders, communication, documentation, and reassessment requirements. Monitoring The Administrator or designee will review the LHPS tracking log monthly for 12 months. Any deficiency will be corrected immediately, and additional staff education will be provided as needed. Completion Date: 06/30/2026	6/30/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 sugars) subcutaneously at bedtime. Review of Resident #1's Resident Register revealed an admission date of 07/11/25. Review of Resident #1's record revealed there was a blank unsigned LHPS assessment. Interview with Resident #1 on 06/09/26 at 1:00pm revealed: -She had been a diabetic for years. -She was taking insulin and checking her FSBS before she was admitted to the facility. -She continued with FSBS checks and insulin administration since her admission to the facility. Telephone interview with the LHPS nurse on 06/09/26 at 11:00am revealed: -She started working for the facility in January 2026. -She did two LHPS assessments in January 2026 and in April 2026; each one was for a FSBS. -She had not done a FSBS for Resident #1; she was not informed that Resident #1 needed an LHPS assessment. -She was given a list of residents who needed an LHPS assessment when she started in January 2026 and Resident #1 was not on the list. -The Owner emailed her the list of residents who required LHPS assessment. -The facility was responsible for letting her know when a task had been ordered for resident and a LHPS assessment was needed. -If Resident #1 had orders for a FSBS and an insulin injection then she should have an LHPS assessment. Telephone interview with the Administrator on 06/09/26 at 3:30pm revealed: -He thought the LHPS nurse checked each chart	D 280		

Division of Health Service Regulation
STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 282	Continued From page 27 The findings are: Review of the Environmental Health Services inspection report dated 02/25/26 revealed the facility sanitation score was an A and they received 0 demerits. Observation of the facility refrigerator on 06/08/26 at 10:05am revealed: -There was an undated zip-locked bag that contained 8 mini pancakes. -There was an undated closed pitcher ¾ full that contained a white liquid. -There was an opened package of turkey breast sandwich meat with no opened date. -There was an unlabeled and undated zip-lock bag that was 1/3 full that contained cooked fries. -There was an aluminum pan that was 1/3 full of a brown substance that had a clear covering over the top that was not sealed. -The aluminum pan was unlabeled and undated. -There were five plastic one-serving containers that were unlabeled and undated. Observation of the facility's dry storage on 06/08/26 at 10:12:am revealed: -There was a undated zip-locked bag that contained dry powdered milk. -There was an open, undated bag of quick oat grits. Interview with a medication aide (MA) on 06/08/26 at 1:06pm revealed: -The food in the refrigerator and in the dry storage should be sealed and labeled with the date the food was opened or prepared. -She did not realize there was food in the refrigerator and the dry storage that was not sealed in a zip-lock bag and was not dated.	D 282	Following the survey, the Administrator and dietary staff inspected all food storage areas. Improperly stored, expired, unlabeled, undated, or unsuitable food items were discarded. Remaining food was properly labeled, dated, covered, and stored. Corrective Action for Residents A facility-wide review of food storage practices was completed to ensure food was maintained in a clean and sanitary manner and protected from contamination. The kitchen was reorganized to promote proper rotation and storage, and food products were checked for expiration dates and proper temperatures. Systemic Changes Standardized food storage procedures were implemented requiring opened food to be labeled with the date opened, covered, and stored according to manufacturer recommendations and food safety standards. A daily kitchen checklist was implemented. Staff received education on safe handling, labeling, dating, cross-contamination prevention, temperature monitoring, and sanitation. Monitoring The Administrator or designee will document weekly kitchen and food storage inspections for 90 days. Refrigerator and freezer temperature logs will be reviewed daily. Thereafter, inspections will be conducted monthly through Quality Assurance. Completion Date: 06/23/2026	6/23/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 282	Continued From page 28 -Whoever opened a package of food or stored leftovers was responsible for sealing and labeling the food. Interview with the second MA on 06/08/26 at 1:40pm revealed: -She was aware that food was to be dated when it was opened. -She knew that opened packages of food had to be sealed; she used zip-locked bags to place packages in when they were opened. -She did not know there was food in the refrigerator or the dry storage closet that was not sealed and not dated. -She always labeled, sealed, and dated the food that she opened. Telephone interview with the Supervisor on 06/09/26 at 2:45pm revealed: -All foods should be sealed, labeled and dated. -She expected all foods to be sealed, labeled and dated. -She was constantly going over this with the staff. Interview with the Administrator on 06/09/26 at 1:49pm revealed he expected the staff to seal and label all open food in the refrigerator and the dry storage cabinet.	D 282			
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers.	D 286			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 286	Continued From page 29 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure mealtime table service included a place setting consisting of a knife, fork, and spoon. The findings are: Observation of the lunch meal service on 06/08/26 from 11:15am to 11:45am revealed: -The residents were served a chicken patty, a hashbrown, homemade biscuits, applesauce, and fruit punch. -There were four residents in the dining room. -Each place setting had a fork and a spoon; there were no knives. -Some residents used their fork to cut their chicken and hashbrown, one resident used his fingers to pick up the food and bite it. Observation of the dinner meal service on 06/08/26 from 3:45pm to 4:15pm revealed: -The residents were served chicken alfredo, cabbage, creamed potatoes, a fruit cup, and fruit punch. -There were 9 residents in the dining room. -Each place setting had a fork and a spoon; there were no knives. Observation of the lunch meal service on	D 286	Following the survey, meal service procedures were reviewed to ensure all residents receive complete place settings, including a plate, appropriate utensils, beverage cup, and napkin, unless adaptive equipment or an alternative setting is required by order or care plan. Corrective Action for Residents The Administrator observed meal service to verify that each resident received an appropriate place setting and any required adaptive dining equipment. Staff were reminded to review care plans before meals. Systemic Changes Meal service procedures were updated to require verification of complete place settings before meals. Dietary and direct care staff received education regarding table service, resident dignity, adaptive equipment, and a pleasant dining experience. Monitoring The Administrator or designee will observe and document meal service weekly for 90 days, then monthly through Quality Assurance. Deficiencies will be corrected immediately. Completion Date: 06/23/2026		6/23/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 286	Continued From page 30 06/09/26 from 11:15am to 11:45am revealed: -The residents were served a turkey sandwich cut in half, greens, a hashbrown, a fruit cup, fruit punch, and milk. -There were three residents in the dining room. -Each place setting had a fork and a spoon; there were no knives. Interview with a medication aide (MA) on 06/09/26 at 9:27am revealed: -She did not put a knife on the table for each place setting at each meal. -She was scared a resident would hurt someone with a knife. -No one had ever told her not to put a knife on the table. -She did not because she was scared too. Telephone interview with the Supervisor on 06/09/26 at 2:45pm revealed: -A place setting consisted of a spoon, fork and a napkin. -The residents were not given knives because some of the residents had mental illness diagnoses. -If the resident needed their food cut up, the MA could cut their food for them. -This was the expectation for all place settings. Interview with the Administrator on 06/09/26 at 1:25pm revealed: -He expected the MAs to provide residents with a place setting consisted of a spoon, fork, and knife. -He did not know the residents were not given a knife at meals. -He was not concerned that the residents would hurt themselves with a knife.	D 286			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 291	Continued From page 31	D 291	Following the survey, the Administrator reviewed menu planning to ensure current menus accurately reflected meals served. Menus were updated, approved, and posted. Discrepancies were corrected immediately. Corrective Action for Residents The Administrator verified that meals served were consistent with the posted menu or that substitutions of equal nutritional value were provided and documented. Systemic Changes A menu review process was implemented requiring dietary staff to follow the approved menu and document substitutions before meal service. Staff received education regarding menu compliance, substitutions, and resident nutritional needs. Monitoring The Administrator or designee will review the posted menu and observe meal service weekly for 90 days, then monthly through Quality Assurance. Completion Date: 06/23/2026	6/23/2026
D 291	10A NCAC 13F .0904(c)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (2) Menus shall be maintained in the kitchen and identified as to the current menu day for guidance of food service staff. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to follow the weekly menus for the guidance of meal preparation. The findings are: Observation of the kitchen on 06/08/26 at 9:55am revealed: -There was a notebook that contained weekly menus. -The notebook was opened and the menu was dated January, February, March 2020. Interview with the (MA) on 06/08/26 at 10:01am revealed: -She worked from 8:00am to 5:00pm Monday through Friday. -She prepared lunch and dinner each day she worked. -She did not use the menu when she prepared the meals; it was an old menu.	D 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 291	Continued From page 32 -She prepared what food was in the facility. -Today for lunch, 06/08/26, she prepared a chicken patty, a hashbrown, homemade biscuits, applesauce, and fruit punch. -Today for dinner, 06/08/26, she was preparing chicken alfredo, cabbage, creamed potatoes, a fruit cup, and fruit punch. Interview with the same MA on 06/09/26 at 9:27am revealed: -She did not prepare the correct meal yesterday because she did not follow the menu. -She thought it was a old menu since it had the year 2020 on it. -She did not follow a menu yesterday when she prepared lunch and dinner. Interview with the second MA on 06/09/26 at 8:15am and 12:24pm revealed: -She did not use a menu when she prepared breakfast yesterday, 06/08/26; she prepared what was available. -Management brought breakfast food in that morning, 06/09/26. Interview with the Administrator on 06/09/26 at 1:25pm revealed: -He was not aware the menus were not being followed. -He expected the MA to follow the menus. -If the food was not available, the MA should substitute for what was not available.	D 291		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in	D 298		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 298	Continued From page 33 accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to offer or make available three snacks a day for the residents. The findings are: Observations of the facility on 06/08/26 between 9:00am and 3:00pm revealed: -There were 4 residents that remained in the facility during the day while the other residents attended a day program. -There were no snacks offered or made available to the residents. Interview with a resident on 06/09/26 at 7:05am revealed: -They used to get snacks of muffins or granola bars at bedtime, but that stopped about 3 months ago. -She did not know why the snacks at bedtime stopped. -She went to the day program from 8:00am to 3:00pm; she did not know if the residents who stayed in the facility were served snacks during the day. Interview with a second resident on 06/09/26 at	D 298	Following the survey, snack service procedures were reviewed to ensure residents receive snacks between meals and at bedtime. Appropriate snack options were made available to all residents. Corrective Action for Residents The Administrator verified that residents are offered scheduled snacks unless restricted by physician orders or dietary plans. A snack service log was implemented. Systemic Changes Dietary procedures were updated to include scheduled snack service. Staff received education regarding snack requirements, portions, therapeutic diets, documentation, and nutritional support. Monitoring The Administrator or designee will observe and document snack service weekly for 90 days and review snack logs. Thereafter, monitoring will continue monthly through Quality Assurance. Completion Date: 06/23/2026	6/23/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 298	Continued From page 34 7:15am revealed: -The facility did not offer or serve snacks at bedtime. -He had to buy his own snacks if he wanted snacks. -There were no snacks offered or served on the weekends between meals or at bedtime. Interview with a third resident on 06/09/26 at 7:30am revealed: -He was not served or offered snack in the facility. -They used to get snacks several months ago, but not anymore. -They did not get snacks on the weekend. -It had been a long time since snacks were served in the facility. Interview with a medication aide (MA) on 06/09/26 at 9:27am revealed: -The residents should get snacks three times a day; between each meal and at bedtime. -She forgot to give the residents a snack yesterday between meals but she did give them a cookie after dinner, before she left for the day at 4:30pm. -If the residents asked for a snack she would give them one. Interview with the second MA on 06/09/26 at 12:24pm revealed: -She did not know anything about serving snacks. -She had not been instructed by her supervisor to serve snacks to the residents. -Each resident had their own snacks. -She ran errands to pick up the residents' snacks that they wanted. Telephone interview with the Supervisor on 06/09/26 at 2:45pm revealed:	D 298		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 298	Continued From page 35 -Snacks should be offered three times a day. -There was plenty of snacks available to serve; fruit cups, granola bars, chips, peanut butter and crackers. Interview with the Administrator on 06/09/26 at 1:25pm revealed: -Snacks should be served three times daily between meals and at bedtime. -He expected snacks to be served three times daily.	D 298		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent of dairy servings were served three times daily to the residents. The findings are:	D 299	Following the survey, meal service practices were reviewed to ensure milk or an approved dairy substitute is offered at every meal. Purchasing procedures were updated to maintain an adequate supply. Corrective Action for Residents The Administrator observed meal service to verify that each resident is offered milk or an approved substitute unless restricted by physician order or dietary plan. Systemic Changes Meal service procedures were revised to verify milk or an approved substitute is available and offered at each meal. Staff received education regarding dairy service, therapeutic substitutions, and balanced meals. Monitoring The Administrator or designee will observe and document meal service weekly for 90 days, then monthly through Quality Assurance. Completion Date: 06/23/2026	6/23/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 299	Continued From page 36 Review of the facility's current census on 06/08/26 revealed there were 9 residents residing in the facility. Review of the weekly menu available for the week of 06/08/26 revealed milk was to be served for breakfast and dinner but was not listed to be served for lunch. Review of the U.S. Department of Agriculture Dietary Guidelines for Americans revealed: -Adults aged 19-59 and 60+ should consume a minimum of the equivalent of 3 cups of a dairy item daily for a 1600-calorie diet. -Recommendations for daily dairy servings included 1 cup (8 ounces) of whole milk, 2% milk, 1% milk, non-fat/skim milk, buttermilk, lactose free milk, evaporated milk, and fortified soy milk. -Milk based dessert included in dairy servings were 1 cup of frozen yogurt, pudding, sherbet, ice cream and a dairy-based smoothie. -Yogurt included in dairy servings were 1 cup of milk-based yogurt, soy yogurt and kefir. -Cheese included in dairy servings were one and a half ounces of sliced or cubed hard or soft natural cheese or one-third of a cup of shredded hard or soft natural cheese, cottage cheese was a 2-cups serving, and ricotta cheese was a half a cup serving. -The dairy serving equivalent of processed American cheese was 2 one-ounce slices or 2 ounces. -Cream cheese, sour cream, and cream were not included as a dairy equivalent due to their low calcium content. -Plant based milks other than soy milk were not included in an equivalent in the dairy group even though they may contain calcium because their overall nutritional content was not similar enough	D 299		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 299	Continued From page 37 to dairy milk and soy milk. Observation of the lunch meal on 06/08/26 at 11:15am revealed: -The residents were served a chicken patty, a hashbrown, homemade biscuits, applesauce, and fruit punch. -There were no dairy products offered at lunch, including milk. Observation of the dinner meal on 06/08/26 at 3:45am revealed: -The residents were served chicken alfredo, cabbage, creamed potatoes, a fruit cup, and fruit punch. -There were no dairy products offered at dinner, including milk. Observation of the kitchen on 06/08/26 at 10:00am revealed there was a 1/2 gallon of milk available for meals. Observation of the kitchen on 06/09/26 at 7:30am revealed there was a gallon of milk available for meals. Interview with a resident on 06/09/26 at 7:05am revealed: -They were not served milk or dairy products every day. -Milk was served with cereal. -They did not have milk that morning or yesterday morning, 06/08/26 and 06/09/26 for breakfast because they were not served cereal. -They were not served milk last night at dinner. -They were not served milk at lunch on the weekends. -She went to the day program Monday through Friday; she did not know if the residents who stayed in the facility during the day received milk	D 299		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 299	Continued From page 38 for lunch. Interview with a second resident on 06/09/26 at 7:15am revealed: -He was served milk if he had cereal. -He was not served milk to drink. -He would like to have milk to drink, but he did not ask for milk. -He drank what he was served. Interview with a third resident on 06/09/26 at 7:30am revealed: -He was served milk very seldom. -He liked milk but did not get it often. -He had not asked the staff for milk when he was not served milk. Interview with a medication aide (MA) on 06/09/26 at 9:27am revealed: -There was one gallon of milk in the refrigerator that morning, 06/09/26. -She thought she served milk to the residents for lunch and dinner yesterday, 06/08/26. -She forgot to serve milk at lunch and dinner. -Sometimes she served powdered milk when she did not have any other milk. -Milk should be served twice a day. -She did not know milk or dairy products should be served three times a day. Telephone interview with the Supervisor on 06/09/26 at 2:45pm revealed: -The MA should serve 8-ounces of milk at each meal. -There were 2 gallons of milk delivered to the facility that morning. -There was enough milk to serve 9 residents 8-ounces of milk for breakfast that morning. -There was also powdered milk in the facility that could be served if there was no whole milk	D 299		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 299	Continued From page 39 available. Interview with the Administrator on 06/09/26 at 1:25pm revealed: -He expected the MAs to serve milk at each meal. -There was powdered milk in the facility if there was no whole milk. -Milk could be brought to the facility anytime it was needed.	D 299		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served at each meal for the residents in addition to other beverages. The findings are: Review of the facility's current census on 06/08/26 revealed there were 9 residents residing in the facility. Observation of the lunch meal on 06/08/26 at 11:15am revealed:	D 306	Following the survey, meal service procedures were reviewed to ensure drinking water is offered to each resident at every meal in addition to other beverages. Additional pitchers and cups were obtained. Corrective Action for Residents The Administrator observed meal service to verify water is offered to each resident, while honoring physician-ordered fluid restrictions. Systemic Changes Meal service procedures were revised to require staff to offer water at every meal. Staff received education regarding hydration, meal service, fluid restrictions, and adequate fluid intake. Monitoring The Administrator or designee will observe and document meal service weekly for 90 days, then monthly through Quality Assurance. Completion Date: 06/23/2026	6/23/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 306	Continued From page 40 -The residents were served a chicken patty, a hashbrown, homemade biscuits, applesauce, and fruit punch. -There was no water offered or served to the residents. Observation of the dinner meal on 06/08/26 at 3:45am revealed: -The residents were served chicken alfredo, cabbage, creamed potatoes, a fruit cup, and fruit punch. -There was no water offered or served to the residents. Observation of the lunch meal on 06/09/26 at 11:15 revealed: -The residents were served a turkey sandwich, greens, a hash brown, a fruit cup, fruit punch, and milk. -There was no water offered or served to the residents. Observation of the kitchen on 06/09/26 at 12:45pm revealed: -There were three stacks of cups in the top cabinet. -Each stack had 9 cups for a total of 27 cups. Interview with a resident on 06/09/26 at 7:15am revealed: -She did not have water that morning with breakfast. -They did not get water with every meal. Interview with another resident on 06/09/26 at 7:25am revealed: -They were served water with some meals but not all meals. -He did not receive water that morning with breakfast.	D 306		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 306	Continued From page 41 -He did not remember being served water yesterday for dinner. Interview with a medication aide (MA) on 06/09/26 at 12:50pm revealed: -She thought she served water to each resident yesterday, 06/08/26, for lunch and dinner. -She did not realize she did not serve water at lunch and dinner yesterday, 06/08/26. -She thought she served water at lunch and dinner; she always served water. -She knew water was to be served at each meal. -She needed more cups; she did not have enough to serve water, milk, and another beverage at each meal. -She thought she had told the Administrator she needed more cups. Interview with the second MA on 06/09/26 at 12:24pm revealed: -Water should be served at every meal. -Water was not served today, 06/09/26, for lunch. -She did not have enough cups to serve milk, water, and juice at each meal. -She had not told the Administrator that more cups were needed. Interview with the Administrator on 06/09/26 at 1:25pm revealed he expected the MAs to serve water at each meal.	D 306			
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 358	Continued From page 42 (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#1) who was ordered insulin. The findings are: Review of Resident #1's current FL-2 dated 03/19/26 revealed: -There was a diagnosis of diabetes mellitus type 1. -There was an order for Novolog insulin 4 units (a fast-acting insulin used to control high blood sugars) three times daily with meals. Review of Resident #1's April 2026 medication administration record (MAR) revealed: -There was an entry for Novolog insulin 4 units three times daily with meals with a scheduled administration times of 8:00am, 2:00pm, and 8:00pm. -There was documentation that Novolog insulin was administered three times daily from 04/01/26 to 04/30/26. Review of Resident #1's May 2026 MAR revealed: -There was an entry for Novolog insulin 4 units three times daily with meals with a scheduled administration times of 8:00am, 2:00pm, and 8:00pm. -There was documentation that Novolog insulin was administered three times daily from 05/01/26 to 05/31/26.	D 358	The facility immediately reviewed Resident #1's physician orders and Medication Administration Record (MAR) to ensure all medications were accurately transcribed and administered as prescribed. The pharmacy was contacted to verify insulin orders, scheduled administration times, and medication availability. Medication administration staff were instructed to administer all medications, including insulin, exactly as ordered by the licensed prescriber, including administration with meals when required. Any discrepancies identified between physician orders, the MAR, or medication availability were corrected immediately. Identification of Other Residents at Risk The Administrator and Registered Nurse completed a 100% audit of all resident physician orders, MARs, and treatment records to verify accurate transcription, correct administration times, proper identification of medications requiring administration with meals, and availability and administration of insulin and other high-risk medications. Discrepancies were corrected immediately, with physician and pharmacy notification as appropriate. Measures to Prevent Recurrence The facility revised its medication management process to require verification of new and revised physician orders against the MAR, verification of administration times when discrepancies are identified, daily review of medication inventory, mandatory use of the MAR during every medication pass, and immediate reporting of medication discrepancies, omissions, unavailable medications, or variances. Medication staff received documented education regarding the Rights of Medication Administration, following orders exactly, prescribed times and meal requirements, accurate documentation, refill procedures, and reporting variances.	7/24/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 358	Continued From page 43 Review of Resident #1's June MAR 2026 from 06/01/26 to 06/08/26 revealed: -There was an entry for Novolog insulin 4 units three times daily with meals with scheduled administration times of 8:00am, 2:00pm, and 8:00pm. -There was documentation that Novolog insulin was administered two times daily from 06/01/26 to 06/08/26 at 8:00am and 8:00pm. -There was no documentation that Novolog insulin was administered from 06/01/26 to 06/08/26 at 2:00pm. Interview with Resident #1 on 06/08/26 at 9:30am revealed: -She was a diabetic. -She received insulin three times a day; in the morning, afternoon, and at bedtime. -She did receive insulin in the morning before breakfast, but she did not receive insulin before lunch or dinner. Telephone interview with a representative from the facility's contracted pharmacy on 06/08/26 at 11:18am revealed: -Resident #1 had an order for Novolog 4 units subcutaneously three times a day with meals. -Novolog was not on cycle fill; the facility had to call the pharmacy when a refill of Novolog was needed. -The pharmacy dispensed one box of 5 Novolog pens on 07/24/25; each pen contained 300 units of insulin. -The 5 Novolog insulin pens would last 125 days; which would have lasted until November 2025. -The facility had not requested a refill for Novolog pens for Resident #1. -When the order was entered into the system it automatically defaulted to a scheduled three	D 358	Monitoring The Administrator will complete weekly medication administration observations for 12 consecutive weeks to verify medications are administered in accordance with physician orders and facility policy. The Administrator will complete weekly MAR audits and medication inventory/refill audits for 12 consecutive weeks to ensure physician orders match the MAR and medications remain available. Findings will be documented, deficiencies corrected immediately, and additional staff education provided as needed. Following the weekly monitoring period, the Administrator will conduct monthly audits through the facility's Quality Assurance/Performance Improvement (QAPI) program. Completion Date: 07/24/2026		7/24/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 358	Continued From page 44 times a day of 8:00am, 2:00pm, and 8:00pm. -The Novolog insulin should be given with meals as ordered. -The facility had not requested the time for the Novolog insulin to be changed to mealtimes. Observation of Resident #1's medication on hand revealed: -There was a box of 5 Novolog pens dispensed on 07/24/25. -There were 3 of the 5 pens that had not been used. -There was 1 pen that had been used and contained 125 units of 300 units. Interview with a medication aide (MA) on 06/08/26 at 1:06pm revealed: -She administered Novolog insulin 4 units to Resident #1 between 2:00pm and 3:00pm. -She administered Resident #1's Novolog insulin 4 units each day. -Resident #1 did not refuse her afternoon insulin. -She did not give Resident #1 her insulin with meals because it was scheduled for 8:00am, 2:00pm, and 8:00pm. -She did not use the MAR to administer Resident #1's insulin so she had not noticed the order read to give the insulin with meals. Interview with the same MA on 06/09/26 at 9:27am revealed: -She did not know if Resident #1 was admitted to the facility with Novolog insulin or not. -Resident #1 had not missed any dosages of Novolog insulin that she was aware of. -She did not know why Resident #1's Novolog had only been ordered once and there were still three new pens in the refrigerator. -She did not know why Resident #1 had extra Novolog insulin on hand.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 358	Continued From page 45 Interview with a second MA on 06/08/26 at 1:40pm revealed: -She had noticed the Novolog insulin was ordered to be administered with meals, but she followed the administration times that the pharmacy had on the MAR. -She had not contacted the pharmacy about the times on the MAR and she had not mentioned it to the Administrator. Interview with the Administrator on 06/09/26 at 1:25pm revealed: -He and the owner admitted Resident #1 to the facility in July 2025. -Resident #1 did not bring any medications into the facility with her. -It did not make sense that the pharmacy had not dispense any Novolog for Resident #1 since 07/24/25. -She may have refused medications at some point. -The MAs should administer the insulin as ordered. Attempted telephone interview with Resident #1's family on 06/09/26 at 2:01pm was unsuccessful. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 06/09/26 at 2:23pm was unsuccessful.	D 358			
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the	D 366			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 366	Continued From page 46 staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) documented on the medication administration record (MAR) immediately after administering medications for 1 of 1 resident (#1). The findings are: Review of Resident #1's current FL2 dated 03/19/26 revealed: -Diagnoses included schizoaffective disorder, bipolar, diabetes mellitus 1, and depressions. -There was an order for Novolog insulin 4 units (a fast-acting insulin used to control high blood sugars) three times daily with meals. -There was an order for fluoxetine 20mg (used to treat major depression) daily. -There was an order for divalproex sodium DR 500mg (used to manage episodes of bipolar disorder twice daily). -There was an order for Lantus insulin 30 units (a long-acting insulin) at bedtime. -There was an order for mirtazapine 7.5mg (used to treat major depression) at bedtime. Review of Resident #1's June 2026 MAR from 06/01/26 to 06/04/26 revealed: -There was an entry for Novolog insulin 4 units three times daily with meals with a scheduled	D 366	The facility immediately reviewed Resident #1's MAR, physician orders, and medication documentation practices. Documentation errors were corrected in accordance with facility policy. Medication staff were instructed that medications must be documented immediately following administration and after observing the resident take the medication, before administering medications to another resident. Pre-charting is prohibited, and only the medication aide who administers the medication may document it. Identification of Other Residents at Risk The Administrator and Registered Nurse completed a 100% audit of all resident MARs and physician orders to verify documentation accurately reflected medications administered, was completed by the administering medication aide, contained no pre-charting, and matched physician orders. Discrepancies were corrected immediately. Measures to Prevent Recurrence Medication documentation procedures were revised to require immediate documentation after administration, completion before moving to another resident, documentation only by the administering medication aide, prohibition of pre-charting, and immediate reporting of errors. All medication staff received documented education regarding 10A NCAC 13F .1004(i), proper MAR completion, the prohibition against pre-charting, and accurate, complete, and timely documentation. Monitoring The Administrator or Registered Nurse will conduct weekly medication pass observations and MAR documentation audits for 12 consecutive weeks to verify documentation is completed immediately following administration, pre-charting does not occur, and entries are completed only by the medication aide administering the medication. Findings will be documented and deficiencies corrected immediately. Thereafter, audits will continue monthly through QAPI. Completion Date: 07/24/2026	7/24/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 366	Continued From page 47 administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation Novolog insulin was administered three times daily. -There was an entry for fluoxetine 20mg daily with a scheduled administration time of 8:00am -There was documentation fluoxetine was administered daily. -There was an entry for divalproex sodium DR 500mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation divalproex sodium DR 500mg was administered twice daily. -There was an entry for Lantus insulin 30 units sq at bedtime with a scheduled administration time of 8:00pm. -There was documentation Lantus insulin 30 units sq at bedtime was administered at bedtime. -There was an entry for mirtazapine 7.5mg at bedtime with a scheduled administration time of 8:00am -There was documentation mirtazapine was administered at bedtime. Review of Resident #1's medications on hand on 06/08/26 at 10:35am revealed: -There was a punch card that contained fluoxetine 20mg with a prescription label that read to administered in the morning. -There was a punch card that contained divalproex sodium DR 500mg with a prescription label that read to administer twice daily. -There was a punch card that contained mirtazapine 7.5mg with a prescription label that read to administer at bedtime. -There was a Novolog insulin pen with instructions to administer 4 units three times daily with meals. -There was a Lantus insulin pen with instructions to administer 30 units at bedtime.	D 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 366	Continued From page 48 Interview with Resident #1 on 06/08/26 at 9:30am revealed there were two MAs who worked and administered medications to her. Interview with the MA on 06/09/26 at 8:59am revealed: -She normally worked 8:00am to 5:00pm, Monday through Friday. -She worked from 06/01/26 at 8:00am until 06/04/26 at 5:00pm because the other MA was on vacation. -There were only two MAs employed at the facility. -She did not sign Resident #1's MAR from 06/01/26 to 06/04/26 when she administered medications. -She administered medications without the MAR and she would forget to sign the MAR. Interview with the second MA on 06/09/26 at 7:45am revealed: -She was on vacation from 06/01/26 to 06/04/26; -The other MA worked while she was on vacation. -The other MA did not sign the MAR when that MA administered medications. -She did not know why the other MA did not sign the MAR after administering the medications. -She would sign her initials on the MAR when there were blanks in the MAR. -She knew she should not sign for medication if she did not administer the medication. -She should have told the other MA to sign the MAR. -She signed her initials on the MAR for resident #1 from 06/01/26 to 06/04/26 after she returned from vacation. Interview with the Administrator on 06/09/26 at 10:30am revealed he expected the MAs to	D 366			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 366	Continued From page 49 document correctly on the MARs.	D 366		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the medication administration record (MAR) was accurate for 2 of 3 residents (#1 and #2) related to an insulin (#1) and a fluoride toothpaste (#2). The findings are:	D 367	The facility immediately reviewed the MARs for Resident #1 and Resident #2 to ensure documentation accurately reflected physician orders and medications actually administered. Errors were corrected. Staff were instructed that medications may only be documented after administration and that unavailable, refused, held, or omitted medications and the reason must be documented. Identification of Other Residents at Risk The Administrator and Registered Nurse completed a 100% audit of all resident MARs, physician orders, and medications on hand to verify accurate entries, actual administration, proper documentation of omissions and refusals, and correct administration times. Discrepancies were corrected immediately. Measures to Prevent Recurrence The facility revised documentation procedures to require accurate transcription of orders, documentation only after administration, documentation of all omissions, refusals, held or unavailable medications, immediate pharmacy and practitioner notification when medication is unavailable, follow-up until medication is received or new orders obtained, and routine refill monitoring. Medication staff received documented education. Monitoring The Administrator or Registered Nurse will conduct weekly MAR audits, medication pass observations, and medication inventory reviews for 12 consecutive weeks. Findings will be documented and deficiencies corrected immediately. Thereafter, MAR audits will continue monthly through QAPI. Completion Date: 07/24/2026	7/24/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 367	Continued From page 50 1. Review of Resident #1's current FL-2 dated 03/19/26 revealed: -There was a diagnosis of diabetes mellitus. -There was an order for Novolog insulin 4 unit (a fast-acting insulin to control elevated blood sugar) three times daily with meals. Review of Resident #1's June 2026 MAR from 06/01/26 to 06/07/26 revealed: -There was an entry for Novolog insulin 4 units three times daily with meals with a scheduled administration time of 8:00am, 2:00pm and 8:00pm. -There was no documentation that Novolog 4 units was administered to Resident #1 at 2:00pm. Interview with Resident #1 on 06/08/26 at 9:30am revealed: -She was a diabetic and received three insulin injections a day; in the morning, afternoon and at bedtime. -She always received her insulin injections. Interview with a MA on 06/09/26 at 10:12am revealed: -She administered the 2:00pm dose of Novolog insulin to Resident #1 as ordered. -She did not realize she forgot to sign the June 2026 MAR for 2:00pm. Interview with the Administrator on 06/09/26 at 10:30am revealed: -He expected the MAs to sign the MARs for the medications they administered. -The person who signed the MAR could be accused of a mistake when it was actually another MA. 2. Review of Resident #2's current FL-2 dated	D 367			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 367	Continued From page 51 03/19/26 revealed: -Diagnoses included bipolar depression and diabetes mellitus. -There was an order for Prevident 5000 (used to prevent tooth decay) brush for 2 full minutes every night after flossing, spit excess toothpaste out. Review of Resident #2's May 2026 MAR revealed: -There was an entry for Prevident 5000 brush for 2 full minutes every night after flossing, spit excess toothpaste out with a scheduled administration time of 8:00am. -There was no documentation that Prevident 5000 was administered from 05/01/26 to 05/31/26; the MAR was blank. -There was a sticky note on the MAR that read, refill requested from the pharmacy on 05/01/26. Review of Resident #2's June 2026 MAR from 06/01/26 to 06/07/26 revealed: -There was an entry for Prevident 5000 brush for 2 full minutes every night after flossing, spit excess toothpaste out with a scheduled administration time of 8:00am. -There was documentation that Prevident 5000 was administered from 06/01/26 to 06/07/26. Observations of Resident #2's medications on hand on 06/07/26 at 1:00pm revealed there was no Prevident 5000 available to be administered as ordered. Telephone interview with a representative from the facility's contracted pharmacy on 06/09/26 at 9:31am revealed: -The Prevident 5000 toothpaste was dispensed upon request of the facility. -The facility made a request for the toothpaste to	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 367	Continued From page 52 be refilled on 05/01/26. -There were no refills on for the Prevident 5000 toothpaste prescription. -A request was sent to Resident #2's dentist on 05/01/26, but the pharmacy had not received an order to refill the prescription. -There was no documentation that the facility had reached out to question why the Prevident 5000 toothpaste had not been filled. Interview with Resident #2 on 06/09/26 at 7:07am revealed: -She did not have the Prevident 5000 toothpaste to brush her teeth with. -She had been out of Prevident toothpaste for over a month. -She needed a new prescription from her dentist. Interview with the medication aide (MA) on 06/09/26 at 7:35am revealed: -Resident #2 did not have Prevident 5000 toothpaste available in the facility. -The pharmacy needed a new prescription and Resident #2's dentist had not sent the new prescription to the pharmacy to have the Prevident 5000 toothpaste filled. -She signed Resident #2's June 2026 MAR by mistake. Interview with the Administrator on 06/09/26 at 10:30am revealed: -He expected the MAs to document correctly on the MARs. -The MARs were not accurate if the MA documented the administration of the toothpaste when it was not administered. Attempted telephone interview with Resident #2's dentist on 06/09/26 at 2:28pm was unsuccessful.	D 367			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 371	Continued From page 53	D 371	The facility immediately removed and discarded all used insulin pen needles and lancets found attached to insulin pens or remaining inside lancet devices. New single-use supplies were obtained. Resident diabetic supplies were reviewed to ensure a new needle is used for every injection and a new lancet for every fingerstick. Approved sharps containers were placed in the medication administration area. Staff were instructed never to reuse, recap, wrap, store, or discard sharps in regular trash. The Administrator and Registered Nurse reviewed residents for signs of infection or injury and notified primary care providers as appropriate. Identification of Other Residents at Risk The Administrator and Registered Nurse completed a 100% audit of residents receiving insulin injections or fingerstick blood sugar checks. The audit included current physician orders, diabetic equipment, supply levels, resident-specific labeling, absence of used sharps on devices, availability of approved sharps containers, and pharmacy refill records. Improperly stored, used, expired, or missing supplies were corrected immediately. Measures to Prevent Recurrence The facility revised infection-control and diabetic-supply procedures to require single-use needles and lancets, immediate removal and disposal in approved sharps containers, resident-specific labeling and storage, hand hygiene and glove use, cleaning of reusable equipment, daily supply review, timely reordering, and documentation of supply orders and receipt. A diabetic-supply inventory log was implemented. Medication aides received documented education and competency validation. Medication aides will not perform insulin injections or fingerstick checks until competency is verified by the Registered Nurse.	7/24/2026
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented for 3 of 3 sampled residents (#1, #2, and #3) including an insulin injection (#1) and fingerstick blood sugar (FSBS) checks (#1, #2, and #3) and the proper disposal of the insulin needles. The findings are: Review of the facility's undated medication administration policy revealed: -Insulin syringes were not to be recapped. -Insulin syringe/needles were to be disposed of in an appropriate container, such as a sharp container. 1. Review of Resident #1's current FL-2 dated 03/19/26 revealed there was a diagnosis of diabetes mellitus type 1. a. Review of Resident #1's current FL-2 dated 03/19/26 revealed:	D 371		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 371	Continued From page 54 -There was an order for Novolog insulin 4 units (a fast-acting insulin used to control high blood sugars) three times daily with meals. -There was an order for Lantus insulin 30 units (a long-acting insulin used to control high blood sugars) subcutaneously at bedtime. Review of Resident #1's April 2026, May 2026, and June 2026 MAR from 06/01/26 to 06/07/26 revealed: -There was an entry for Novolog insulin inject 4 units three times daily with meals with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was an entry for Lantus insulin inject 30 units at bedtime with a scheduled administration time of 8:00pm. Observation of the insulin pens in the refrigerator on 06/08/26 at 10:26am revealed: -There was a used Novolog insulin pen for Resident #1 in the unlocked metal box. -When the pen cap was removed there was a needle attached to Resident #1's Novolog pen. -The needle was bent at 45 degrees. -There was a Lantus insulin pen for Resident #1 in the unlocked metal box -When the pen cap was removed there was a needle attached to Resident #1's Lantus pen. -The needle was slightly bent. Observation of the medication closet on 06/08/26 at 10:50am revealed: -Resident #1 had a box of 100 insulin pen needles in the medication room for use dispensed on 01/28/26. -There were 83 of 100 insulin pen needles remaining in the box. -Instructions on the box of insulin pen needles read, single-use pen needles.	D 371	Monitoring The Registered Nurse or LHPS Nurse will directly observe insulin administration and fingerstick blood sugar procedures for each medication aide weekly for 12 consecutive weeks. The Administrator will complete weekly audits of diabetic supplies, sharps containers, medication storage areas, and pharmacy refill records for 12 consecutive weeks. Findings will be documented, concerns corrected immediately, and involved staff retrained and revalidated before independently performing the procedure. Thereafter, observations and audits will continue monthly through QAPI. Completion Date: 07/24/2026	7/24/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 371	Continued From page 55 Telephone interview with a representative for the facility's contracted pharmacy on 06/09/26 at 9:31am revealed: -The pharmacy dispensed a box of 100 insulin pen needles on 01/28/26. -Resident #1 had an order for Novolog 4 units three times daily with meals and Lantus 30 units at night dated 07/24/25. -Resident #1 required 4 insulin pen needles a day to administer the Novolog insulin and Lantus insulin as ordered. -The box of 100 insulin pen needles would last 25 days. -The pharmacy had not dispensed anymore insulin pen needles for Resident #1. -Resident #1 was the only resident who received insulin in the facility. Interview with a medication aide (MA) on 06/08/26 at 10:15am revealed: -She administered an insulin injection to Resident #1 between 2:00pm and 3:00pm each day she worked. -The needles were already on the insulin pens when she administered the afternoon insulin. -Sometimes there were no needles in the facility and she had to use the same needle that was left on the insulin pen. -She did not know Resident #1 had needles for the insulin pen in the medication room. -The needles should not be reused and should be discarded in the thick red box. -She did not think the facility had a thick red box to dispose of the needles into. Interview with a second MA on 06/08/26 at 1:40pm revealed: -She left the insulin pen needle on the insulin pens after she administered insulin to the	D 371			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 371	Continued From page 56 resident. -She re-capped the needle while on the insulin pen and returned the insulin pen to the refrigerator. -She would change the needle before she administered the next dose of insulin. -She did not think she had used a needle more than once to administer insulin. -She did not know if the other MA changed the needle or not when she administered insulin. -When she removed the needle from the insulin pen she wrapped it in a paper towel and placed it in the dumpster. Second interview with the second MA on 06/09/26 at 10:12am revealed: -She called the pharmacy when Resident #1 needed more insulin pen needles. -She did not recall re-ordering any insulin pen needles. Interview with the Administrator on 06/08/26 at 11:48am revealed: -The MAs should remove the insulin pen needle and discard the needle after each injection. -The insulin pen needles were not to be reused. -Resident #1's insulin pens should be ordered from the pharmacy when needed. -There was a sharps container available for the needles to be disposed in. Refer to the telephone interview with a representative for the facility's contracted pharmacy on 06/09/26 at 9:31am. Refer to the interview with the Administrator on 06/08/26 at 11:48am. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 06/09/26 at	D 371			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 371	Continued From page 57 2:33pm was unsuccessful. b. Review of Resident #1's current FL-2 dated 03/19/26 revealed: -There was an order to check Resident #1's FSBS three times daily. -There was an order for accu-check lancets as directed. Observation of Resident #1's black zipped case containing her glucometer revealed: -Resident #1's name was on the inside of the black zipped case. -There was a lancet device used to check FSBS inside of the black zipped case. -There was a lancet in the lancet device that was seen when the cap of the lancet device was removed. Observation of Resident #1's diabetic supplies on 06/08/26 at 10:53am revealed: -There was a sealed box of lancets with a dispensed date of 08/18/25 available for use. -Instructions on the sealed box of lancets read, single-use lancets. Interview with Resident #1 on 06/09/26 at 7:55am revealed: -Her FSBS was checked every morning. -She did not know if the MA changed the lancet in lancet device before her FSBS was checked each morning. Interview with a MA on 06/08/26 at 10:15am revealed: -Resident #1 checked her own FSBS. -She gave Resident #1 the lancet device to stick her finger with. -She did not change the lancet in the lancet device; she did not know the lancet needed to be	D 371		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 371	Continued From page 58 changed. -She did not know Resident #1 had any more lancets available to use. Interview with a second MA on 06/08/26 at 1:40pm revealed: -She knew the lancets were left in the lancet device; she replaced the cap over the lancet after it was used. -She removed the lancet from the lancet device and placed a new lancet in the lancet device before each use. -Sometimes there were no new lancets to replace before each FSBS check. -Each resident had their own lancet device in the black zipped bag with their glucometer. -The lancets and insulin needles were ordered from the pharmacy. -She did not recall ordering any needles or lancets from the pharmacy. Telephone interview with a representative from the facility's contracted pharmacy on 06/09/26 at 9:31am revealed: -The pharmacy dispensed a box of 100 lancets for Resident #1 on 8/18/25. -Resident #1 had an order to check her FSBS three times daily before meals. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 06/09/26 at 2:33pm was unsuccessful. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 06/09/26 at 9:31am. Refer to the interview with the Administrator on 06/08/26 at 11:48am.	D 371			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 371	Continued From page 59 2. Review of Resident #2's current FL-2 dated 03/19/26 revealed: -There was a diagnosis of diabetes. -There was an order for lancets for use as directed. -There was an order to check fingerstick blood sugar (FSBS) every morning. Observation of Resident #2's black zipped case containing her glucometer revealed: -Resident #2's name was on the inside of the black zipped case. -There was a lancet device inside of the black zipped case. -There was a lancet in the lancet device that was seen when the cap of the lancet device was removed. Observation of Resident #2's diabetic supplies on 06/08/26 at 10:53am revealed there were no lancets available for use. Interview with Resident #2 on 06/09/26 at 7:55am revealed: -She checked her FSBS every morning when the MA brought her glucometer to her. -She thought the medication aide (MA) placed a new lancet in the lancet device before it was given to her. Interview with a MA on 06/08/26 at 1:40pm revealed: -She knew the lancets were left in the lancet device; she replaced the cap over the lancet after it was used. -She removed the lancet from the lancet device and placed a new lancet in the lancet device before each use. -Sometimes there were no new lancets to replace before each FSBS check.	D 371			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 371	Continued From page 60 -Each resident had their own lancet device in the black zipped bag with their glucometer. -The lancets and insulin needles were ordered from the pharmacy. -She did not recall ordering any needles or lancets from the pharmacy. Telephone interview with a representative from the facility's contracted pharmacy on 06/09/26 at 9:31am revealed: -Resident #2 had an order to check her FSBS daily. -The pharmacy had not dispensed lancets for Resident #2 in over 2 years. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 06/09/26 at 2:33pm was unsuccessful. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 06/09/26 at 9:31am. Refer to the interview with the Administrator on 06/08/26 at 11:48am. 3. Review of Resident #3's current FL-2 dated 03/19/26 revealed: -Diagnoses included dementia, schizoaffective bipolar type, hyperlipidemia, and mild intellectual disability. -There was an order to check Resident #3's FSBS every morning. Observation of Resident #3's black zipped case containing her glucometer revealed: -Resident #3's name was on the inside of the black zipped case. -There was a lancet device inside of the black zipped case.	D 371			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 371	Continued From page 61 -There was a lancet in the lancet device that was seen when the cap of the lancet device was removed. Observation of Resident #3's diabetic supplies on 06/08/26 at 10:53am revealed there were no lancets available for use. Interview with Resident #3 on 06/09/26 at 7:55am revealed: -His fingerstick blood sugar (FSBS) was checked every morning. -He did not know if the medication aide (MA) changed the lancet in lancet device before his FSBS was checked each morning. Interview with a MA on 06/08/26 at 1:40pm revealed: -She knew the lancets were left in the lancet device; she replaced the cap over the lancet after it was used. -She removed the lancet from the lancet device and placed a new lancet in the lancet device before each use. -Sometimes there were no new lancets to replace before each FSBS check. -Each resident had their own lancet device in the black zipped bag with their glucometer. -The lancets and insulin needles were ordered from the pharmacy. -She did not recall ordering any needles or lancets from the pharmacy. Telephone interview with a representative from the facility's contracted pharmacy on 06/09/26 at 9:31am revealed: -Resident #3 had an order to check his FSBS daily. -There was an order for lancets. -The pharmacy dispensed a box of 50 lancets on	D 371			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 371	Continued From page 62 12/30/25, 01/28/26, and 04/24/26. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 06/09/26 at 2:33pm was unsuccessful. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 06/09/26 at 9:31am. Refer to the interview with the Administrator on 06/08/26 at 11:48am. Telephone interview with a representative from the facility's contracted pharmacy on 06/09/26 at 9:31am revealed: -Insulin needles and lancets were not on cycle fill. -The facility had to call the pharmacy when residents needed needles or lancets. -Insulin needle pens and lancets were only for single use only. Interview with the Administrator on 06/08/26 at 11:48am revealed: -Insulin needles and lancets should be discarded after each use. -There was a risk of infection and contamination to the residents. The facility failed to ensure infection control measures were followed when administering insulin by ensuring a new insulin pen needle was used with each insulin injection (#1) and during FSBS checks ensuring a new lancet was used with each FSBS for three residents (#1, #2, and #3). Repeated use of a single-use pen needle and a single-use lancet could lead to blood-borne pathogen infections. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.	D 371			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 371	Continued From page 63 The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/08/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 24, 2026.	D 371			
D 383	10A NCAC 13F .1006 (g) Medication Storage 10A NCAC 13F .1006 Medication Storage (g) Medications shall not be stored in a refrigerator containing non-medications and non-medication related items, except when stored in a separate container. The container shall be locked when storing medications unless the refrigerator is locked or is located in a locked medication area. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medications in the refrigerator were secure. The findings are: Observation of the refrigerator in the kitchen on 06/08/26 at 10:05am revealed: -On the second shelf of the refrigerator door was a metal box. -On top of the metal box was a zip-locked bag that contained a box of 5 insulin pens. -The metal box was not locked; it was ½ inch from being closed.	D 383	The facility immediately removed refrigerated medications stored outside a secured medication container. A lockable medication storage container of sufficient size was obtained and placed inside the kitchen refrigerator. All insulin pens, eye drops, and other refrigerated medications were placed inside the locked container. The Administrator verified the container remained fully closed and locked when not in use. Identification of Other Residents at Risk The Administrator completed a 100% inspection of all medication storage areas, including the refrigerator, medication room, carts, cabinets, and resident-specific containers, to verify refrigerated medications were stored in a separate locked container, storage capacity was adequate, medications were properly labeled, and access was limited to authorized staff. Measures to Prevent Recurrence Medication storage procedures were revised to require all refrigerated medications to be stored in a separate locked container unless the refrigerator itself is secured, containers to remain closed and locked, medications to be separated from food and non-medication items, and staff to report damaged or inadequate containers immediately. Medication staff received documented education regarding 10A NCAC 13F .1006(g). Monitoring The Administrator or designee will inspect the refrigerator and all medication storage areas weekly for 12 consecutive weeks. Findings will be documented and concerns corrected immediately. Thereafter, inspections will continue monthly through QAPI. Completion Date: 07/24/2026		7/24/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 383	Continued From page 64 -In the metal box was a box of insulin pens that contained three unused pens, two used insulin pens, and an opened bottle of eye drops. -On the third shelf of the refrigerator door was an unopened box of 5 insulin pens, one sealed box of eye drops, and one opened bottle of eye drops in a zip-locked bag. Observation of the refrigerator in the kitchen on 06/09/26 at 9:55am revealed: -There were two metal boxes on the shelf in the refrigerator door. -All the refrigerated medications had been placed in the two metal boxes. -The medications remained unlocked; the metal boxes did not have locks on them. Interview with a medication aide (MA) revealed: -She knew the medications in the refrigerator were to be secured in a locked box. -The box in the refrigerator was too small to hold the medications, and the box did not lock. -She thought she had told the Administrator that a bigger box that locked was needed for the refrigerator. Interview with the second MA on 06/08/26 at 1:40pm revealed: -She knew the medications in the refrigerator were to be locked in a lock box. -She knew the box was not locked; there was no lock on the box. -There were too many refrigerated medications to go in the box. -They needed a larger box and a box that would lock. -She did not notice there were medications on two refrigerator door shelves. Interview with the Administrator on 06/09/26 at	D 383			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 383	Continued From page 65 1:49pm revealed: -The medications in the refrigerator were to be locked. -He did not recall a MA requesting a need for a larger locked box for the refrigerator.	D 383			
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable controlled substance count sheet (CSCS) that accurately reconciled the receipt, administration, and disposition of a controlled medication for 3 of 3 sampled residents (#3, #4, and #5) related to a medications for anxiety (#3, #4, and #5). The findings are: 1. Review of Resident #3's current FL-2 dated 03/19/26 revealed: -Diagnoses included schizoaffective bipolar disorder, dementia, and mild intellectual disability. -There was an order for lorazepam 0.5mg (used to treat anxiety) twice daily. Review of Resident #3's June 2026 medication administration record (MAR) from 06/01/26 to 06/08/26 revealed:	D 392			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 392	Continued From page 66 -There was an entry for lorazepam 0.5mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation lorazepam was administered to Resident #3 from 06/01/26 to 06/06/26 at 8:00am. -The MAR was blank from 06/06/26 at 8:00pm to 06/08/26. -There was no CSCS sheet with the MARs. Observation of Resident #3's medication on hand on 06/08/26 at 2:59pm revealed: -There were two punch cards with 28 lorazepam 0.5mg tablets in each card dispensed on 05/24/26. -One punch card had 17 of 28 lorazepam 0.5mg tablets remaining and the second punch card had 26 of the 28 lorazepam 0.5mg tablets remaining. -There was a CSCS attached to the punch cards. -There was no documentation on the CSCS. Refer to the telephone interview with a representative from the facility contracted pharmacy on 06/09/26 at 9:31am. Refer to the interview with a medication aide (MA) on 06/09/26 at 10:12am. Refer to the interview with the second MA on 06/09/26 at 7:45am. Refer to the interview with the Administrator on 06/09/26 at 10:30am. 2. Review of Resident #4's current FL-2 dated 03/19/26 revealed: -There was a diagnosis of other intellectual disabilities. -There was an order for lorazepam 0.5mg (used to treat anxiety) twice daily.	D 392	The facility immediately reviewed controlled substances, MARs, and Controlled Substance Count Sheets for Residents #3, #4, and #5. The Administrator and Registered Nurse completed physical counts and compared quantities on hand with pharmacy dispensing information, MAR documentation, and controlled substance records. Count sheets were placed with corresponding resident records and medication packages. Discrepancies were investigated, documented, and reported as appropriate. Identification of Other Residents at Risk The Administrator and Registered Nurse completed a 100% audit of all controlled substances to verify current count sheets, complete receipt and administration documentation, accurate remaining balances, consistency with the MAR, documentation by the administering medication aide, retrievable records, and proper disposition of discontinued, expired, returned, or destroyed medications. Measures to Prevent Recurrence Controlled-substance procedures were revised to require a count sheet for every controlled medication, documentation of receipt, administration, remaining quantity and disposition, documentation by the administering medication aide, balance verification after each administration, shift-change reconciliation, immediate reporting of discrepancies, retention of completed records, and verification that new controlled medications arrive with count sheets. Medication staff received documented education. Monitoring The Administrator or Registered Nurse will complete weekly controlled-substance audits for 12 consecutive weeks, including a physical count, comparison with the count sheet and MAR, verification of documenting staff, and review of receipt and disposition records. Findings will be documented and discrepancies investigated and corrected immediately. Thereafter, audits will continue monthly through QAPI. Completion Date: 07/24/2026	7/24/2026

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
(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 392	Continued From page 67 Review of Resident #4's June 2026 medication administration record (MAR) from 06/01/26 to 06/08/26 revealed: -There was an entry for lorazepam 0.5mg twice daily. -There was documentation lorazepam was administered to Resident #4 from 06/01/26 to 06/08/26. -There was no CSCS sheet with the MARs. Observation of Resident #4's medication on hand on 06/08/26 at 3:02pm revealed: -There were two punch cards with 28 lorazepam 0.5mg tablets in each card dispensed on 05/24/26 -One punch card had 20 of 28 lorazepam 0.5mg tablets remaining and the second punch card had 21 of the 28 lorazepam 0.5mg tablets remaining. -There was a CSCS attached to the punch cards. -There was no documentation on the CSCS. Refer to the telephone interview with a representative from the facility contracted pharmacy on 06/09/26 at 9:31am. Refer to the interview with a medication aide (MA) on 06/09/26 at 10:12am. Refer to the interview with the second MA on 06/09/26 at 7:45am. Refer to the interview with the Administrator on 06/09/26 at 10:30am. 3. Review of Resident #5's current FL-2 dated 03/19/26 revealed: -Diagnoses included schizoaffective bipolar type and hypertension. -There was an order for clonazepam 0.5mg (used	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 392	Continued From page 68 to treat anxiety) one tablet in the morning and two tablets at bedtime. Review of Resident #5's June 2026 medication administration record (MAR) from 06/01/26 to 06/08/26 revealed: -There was an entry for clonazepam 0.5mg one tablet in the morning. -There was documentation clonazepam had been administered in the morning. -There was an entry for clonazepam 0.5mg two tablets at bedtime. -There was documentation clonazepam had been administered at bedtime. -There was no CSCS with the MARs. Observation of Resident #5's medication on hand on 06/08/26 at 3:06pm revealed: -There was one punch card with 28 clonazepam 0.5mg tablets dispensed on 05/24/26. -There were 20 of 28 clonazepam tablets remaining in the punch card. -There was one punch card with 56 clonazepam 0.5mg tablets dispensed on 05/24/26. -There were 42 of 56 clonazepam tablets remaining in the punch card. -There was a CSCS attached to the punch cards. -There was no documentation on the CSCS. Refer to the telephone interview with a representative from the facility contracted pharmacy on 06/09/26 at 9:31am. Refer to the interview with a medication aide (MA) on 06/09/26 at 10:12am. Refer to the interview with the second MA on 06/09/26 at 7:45am. Refer to the interview with the Administrator on	D 392			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 111 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379			
(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 392	Continued From page 69 06/09/26 at 10:30am. Telephone interview with a representative from the facility's contracted pharmacy on 06/09/26 at 9:31am revealed: -A CSCS was sent with each blister pack of controlled substances. -If the controlled substance was scheduled, the pharmacy dispensed a 28 day supply on cycle-fill. -All scheduled controlled medications for the facility were dispensed on 05/24/26 to start on 06/01/26. -The CSCS sheets were used to document each time a controlled substance was administered. -The CSCS was to ensure the count of the controlled substance was accurate. Interview with a MA on 06/09/26 at 10:12am revealed: -She administered the controlled substances to the resident from 06/01/26 to 06/04/26. -She forgot to sign the CSCS when she administered the controlled substances. -She should have signed to CSCS so the pills that were missing from the punch card would be accounted for. Interview with the second MA on 06/09/26 at 7:45am and revealed: -She removed the CSCS sheets that were attached to the blister pack of medication and placed them in the MAR notebook. -She had not signed the CSCS sheets for the month of June 2026 because they were not with the MARs. -She signed the June 2026 CSCS sheets that morning for all the residents. -She should document on the CSCS sheets each time she administered a controlled substance to ensure the medication on hand matched the	D 392			