Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Rutherford County Department of Social Services conducted an annual and follow-up survey on June 23-25, 2026.	D 000		
D 124	10A NCAC 13F .0402 Qualifications Of Manager 10A NCAC 13F .0402 Qualifications Of Manager The facility shall designate a manager when the administrator is absent from the facility. The manager, is responsible for carrying out the day-to-day operations of an adult care home in the absence of the administrator. The administrator remains ultimately responsible for the adult care home, and the manager shall serve under the direction and supervision of the administrator. The manager shall meet the following requirements: (1) be 21 years or older; (2) be a high school graduate or certified under the G.E.D. program, or if hired before September 1, 2024, have passed the alternative examination established by the Department; (3) have six months training or experience related to management or supervision in long term care or health care settings or be a licensed health professional such as a mental health professional, nurse practitioner, physician assistant, or registered nurse, a nursing home administrator certified pursuant to G.S. 90-276(4), or an assisted living administrator certified pursuant to G.S. 90-288.14; and (4) earn 12 hours a year of continuing education credits in the management of adult care homes or care of the elderly and individuals with physical, intellectual, or developmental disabilities, cognitive impairment, and mental illness.	D 124		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Elizabeth Alexander

LSB reviewed and acknowledged 08/10/26
8/7/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 124	Continued From page 1	D 124		

This Rule is not met as evidenced by:
Based on interviews and record review the facility failed to designate a qualified Manager in the absence of an Administrator.

The findings are:

Review of the Manager's personnel record revealed:
-She was hired on 08/16/24 as a personal care aide (PCA).
-She took her 15-hour medication aide training on 10/11/24.
-She had her medication aide Clinical Skills checkoff on 10/11/24.
-She passed her medication aide (MA) test on 01/15/25.
-There was no documentation of 12 hours a year of continuing education.
-She became the Resident Care Coordinator (RCC) on 06/16/25.

Interviews with the Manager on 06/24/26 at 9:32am and 1:40pm and on 06/25/26 at 12:45pm revealed:
-She was the RCC at the facility for about 4 months prior to becoming the Manager.
-The RCC who trained her was "useless" and did not train her, so she had to learn everything herself.
-She was "thrown into" the Manager position when the previous Administrator walked out.
-She was not able to "do it all" but she tried her best.
-The Regional Operations Director explained the job duties to her, but she was unaware of how many problems and issues that were happening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 124	Continued From page 2 Interviews with the Regional Operations Director on 06/24/26 at 8:37am and 06/25/26 at 3:29pm revealed: -The Manager was hired at the facility until a new Administrator could start in July 2026. -She thought the RCC was qualified to be the Manager because she had prior experience as a manager at a physician's office. -She thought the Manager could do all the necessary jobs temporarily since they had only 10 residents and were not at capacity. -The Manager was trying to "do it all and is afraid to say it is too much".	D 124		
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: Based on observation, interviews and record reviews, the facility failed to ensure 2 of 4 sampled medication aides (Staff B and Staff D) had completed the 5 and 10 or 15-hour medication class with valid instruction and completed the Medication Aide Clinical Skills Competency Validation prior to administering medications.	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 3 The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired as a personal care aide (PCA) on 02/03/25. -Staff B completed the 5-hour MA training course online on 06/14/26. -Staff B completed the 10-hour MA training course online on 06/12/26. -There was no documentation Staff B had completed the MA Clinical Skills Competency Validation checklist. -There was no documentation Staff B had completed the Medication Aide Test. Review of a resident's electronic medication administration record (eMAR) from June 2026 revealed there was documentation Staff B administered lorazepam (a controlled substance used to treat anxiety) 1mg on 06/14/26 at 7:00am. Review of another resident's May 2026 eMAR revealed: -Staff B administered humalog insulin on 05/15/26 and 05/16/26 at 7:30am, 11:30am and 4:30pm. -Staff B administered humalog insulin on 05/17/26 and 5/26/26 at 11:30am and 4:30pm. -Staff B administered humalog insulin on 05/20/26 at 7:30am. Review of the same resident's June 2026 eMAR revealed: -Staff B administered lantus insulin on 06/13/26 and 06/21/26 at 7:00pm and on 06/14/26 at 7:00am. -Staff B administered humalog insulin on 06/17/26 at 11:30am and 4:30pm, on 06/20/26 at	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 4 7:30am, 11:30am and 4:30pm and on 06/21/26 and 06/22/26 at 11:30am. Review of a third resident's April 2026 eMAR revealed: -Staff B administered lorazepam on 04/14/26, 04/18/26 and 04/21/26 at 7:00am. -Staff B administered lorazepam on 04/14/26, and 04/18/26 at 1:00pm. -Staff B administered lorazepam on 04/14/26, and 04/21/26 at 7:00pm. Review of the same resident's May 2026 eMAR revealed: -Staff B administered lorazepam on 05/02/26, 05/03/26, 05/15/26-05/17/26, and 05/29/26 at 8:00am. -Staff B administered lorazepam on 05/03/26, 05/07/26, 05/15/26-05/17/26, and 05/26/26 at 1:00pm. -Staff B administered lorazepam on 05/02/26 at 8:00pm. Review of the same resident's June 2026 eMAR revealed: -Staff B administered lorazepam on 06/12/26, 06/13/26, 06/17/26 and 06/20/26 - 06/23/26 at 8:00am. -Staff B administered lorazepam on 06/12/26, 06/16/26, 06/17/26, 06/20/26 - 06/22/26 at 1:00pm. Interview with Staff B on 06/24/26 at 4:55pm revealed: -She had not been checked off on her MA clinical skills. -The previous Administrator was supposed to set it up with the pharmacy, but never did so. Interview with the Manager on 06/24/26 at	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 5 3:55pm revealed: -Staff B was hired by the previous Administrator. -The previous Administrator was responsible for setting up the Clinial Skills Competency checkoff with the pharmacy. 2. Review of Staff D's personnel record revealed: -Staff D was hired as a MA in training on 06/16/26. -Staff D completed the 5 and 10-hour MA training course online on 06/11/26. -There was no documentation Staff D had completed the MA Clinical Skills Competency Validation checklist. -There was no documentation Staff D had completed the Medication Aide Test. Observation of Staff D on 06/24/26 at 8:10am revealed she was the only staff working at the facility beside the cook who was in the kitchen. Review of a resident's eMAR from June 2026 revealed: -There was documentation Staff D administered lorazepam (used to treat anxiety) 1mg on 06/19/26 and 06/23/26 at 7:00am. -There was documentation Staff D administered lorazepam 1mg on 06/19/26 and 06/22/26 at 7:00pm. -There was documentation Staff D administered trazodone (used to treat insomnia) 150mg on 06/17/26, 06/18/26, 06/19/26 and 06/22/26 at 7:00pm. -There was documentation Staff D administered mirtazapine (used to treat depression) 30mg on 06/17/26, 06/18/26, 06/19/26 and 06/22/26 at 7:00pm. Review of another resident's June 2026 eMAR revealed:	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 6 -Staff D administered lantus insulin (used to treat diabetes) on 06/17/26 and 06/19/26 at 7:00am. -Staff D administered lantus insulin on 06/17/26, 06/18/26 and 06/22/26 at 7:00pm. -Staff D administered lispro insulin (used to treat diabetes) on 06/18/26 at at 7:30am and 11:30am. Interview with Staff D on 06/24/26 at 8:00am revealed: -The Manager hired her to be a MA from 7:00am to 7:00pm but she had worked 7:00pm to 7:00am twice. -She administered resident medications without supervision earlier today (06/24/26). -She took the on-line medication classes before she started working at the facility but she did not have her MA clinical skills validated yet. Interview with the Regional Operations Director on 06/24/26 at 8:36am revealed: -Staff D was just recently hired. -Staff D should not administer medications without supervision if she had not had her MA clinical skills validated by the nurse from the contracted pharmacy. Interview with the Manager on 06/24/26 at 9:32am revealed: -Staff D did not have her MA clinical skill validated before she was assigned to the medication cart because she did not have time to arrange for the nurse to come to the facility and complete it. -She assigned her to the cart without being fully trained because she had so many staff quit and she just needed someone quick to work as a MA.	D 125		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 139	Continued From page 7 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to complete a criminal background check or obtain a consent for a criminal background check for 1 of 4 sampled staff (Staff D). The findings are: Review of Staff D's personnel record review revealed: -Staff D was hired on 06/16/26. -There was documentation Staff D was employed as a medication aide (MA) in training. -There was no documentation of a consent for a criminal background check. -There was no documentation of a criminal background check prior to being hired. Interview with Staff D on 06/24/26 at 2:00pm revealed a criminal background check was not conducted when she was hired recently. Interview with the Manager on 06/24/26 at 9:32am and on 06/25/26 at 2:55pm revealed: -She did not complete a criminal background check on Staff D before she was hired because she had so many staff quit recently and she needed someone to start work quickly. -She did not know all the steps that were required before a new employee started working and the Regional Operations Director was aware it was not completed.	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 139	Continued From page 8 Telephone interview with the Regional Operations Director on 06/24/26 at 8:37am revealed: -She thought the "ball was dropped" on Staff D's new hiring process. -She and the Manager spoke about what needed to be completed and maybe the Manager thought she was going to do it.	D 139		
D 140	10A NCAC 13F .0407(a)(8) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure documentation of signed consent for the examination and screening for the presence of controlled substances was completed for 1 of 4 sampled staff (Staff D). The findings are: Review of Staff D's personnel record review revealed: -Staff D was hired on 06/16/26. -There was documentation Staff D was employed as a medication aide (MA) in training. -There was no documentation Staff D completed a consent for a controlled substance screening. -There was no documentation Staff D completed a controlled substance screening upon hire.	D 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 140	Continued From page 9 Interview with Staff D on 06/24/26 at 2:00pm revealed she did not sign a consent for or take an examination and screening for the presence of controlled substances when she was hired recently. Interview with the Manager on 06/24/26 at 9:32am and on 06/25/26 at 2:55pm revealed: -She did not complete an examination and screening for the presence of controlled substances on Staff D before she was hired. -She did not do the pre-hire testing on Staff D because she had so many staff quit recently and she needed someone to start work quickly. -She did not know all the steps that were required before a new employee started working and the Regional Operations Director knew it was not all done. Telephone interview with the Regional Operations Director on 06/24/26 at 8:37am revealed: -She thought the "ball was dropped" on Staff D's new hiring process. -She and the Manager spoke about what needed to be completed and maybe the Manager thought she was going to do it.	D 140		
D 151	10A NCAC 13F .0501 (c) Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (c) The facility shall assure that staff who perform or directly supervise staff who perform personal care receive training and supervision on the performance of individual job assignments prior to meeting the training and competency requirements of this Rule. Documentation of	D 151		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 151	Continued From page 10 training shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff who perform personal care receive training and supervision prior to meeting the training and competency requirements to be a personal care aide (PCA) for 1 of 4 sampled staff (Staff D). The findings are: Review of Staff D's personnel record review revealed: -Staff D was hired on 06/16/26. -There was documentation Staff D was employed as a medication aide (MA) in training. -There was no documentation Staff D had completed the 80-hour required PCA training competency evaluation course. Interviews with Staff D on 06/24/26 at 8:00am and 2:00pm revealed: -The Manager hired her to work as a PCA/MA from 7:00am to 7:00pm but she worked 7:00pm to 7:00am twice. -She had not completed any PCA training prior to starting work at the facility. -Her training has been by working with the other MAs. -Her PCA job duties included helping residents with showers, assisting residents at mealtime, providing incontinence care to one resident and assisting one resident who needed help transitioning from seated to standing.	D 151		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 151	Continued From page 11 -She spent a lot of her day monitoring one resident who had severe dementia and needed "eyes on" at all times. Interview with the Manager on 06/24/26 at 9:32am revealed she did not complete any training with Staff D because she was one person and could not work 24/7 and she needed Staff D to start working quickly because so many staff had recently quit. Telephone interview with the Regional Operations Director on 06/24/26 at 8:37am revealed Staff D should not be working by herself yet because she was just hired.	D 151		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by:	D 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 167	Continued From page 12 TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure there was at least one staff on the premises at all times who completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management, including the Heimlich maneuver, for 3 or 5 sampled staff (Staff C, Staff D, and Staff E). The findings are: 1. Review of Staff C's personnel record revealed: -Staff C was hired on 09/02/24 as a personal care aide (PCA). -Staff C's CPR certificate was dated 09/05/23. Review of the staffing schedule from 06/10/26 through 06/23/26 revealed Staff C was the only staff member on night shift (7:00pm - 7:00am) from 06/09/26 - 06/12/26 and 06/14/26 - 06/21/26 for a total of 12-night shifts. Refer to interview with the Manager on 06/25/26 at 12:50am. Refer to interview with the Regional Operations Director on 06/25/26 at 3:30pm. Refer to telephone interview with the contracted PCP on 06/25/26 at 12:41pm. 2. Review of Staff D's personnel record revealed: -Staff D was hired on 06/16/26 as a medication aide (MA) in training. -There was no documentation of a CPR certificate. Interview with Staff D on 06/24/26 at 8:00am	D 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 167	Continued From page 13 revealed she was CPR certified in the past but she did not think it was still current. Review of the staffing schedule from 06/10/26 through 06/23/26 revealed Staff D was the only staff member on night shift (7:00pm - 7:00am) on 06/22/26 and 06/23/26 for a total of 2-night shifts. Refer to interview with the Manager on 06/25/26 at 12:50am. Refer to interview with the Regional Operations Director on 06/25/26 at 3:30pm. Refer to telephone interview with the contracted PCP on 06/25/26 at 12:41pm. 3. Review of Staff E's personnel record revealed: -Staff E was hired on 05/14/26 as a PCA and MA. -There was no documentation of a CPR certificate. Review of the staffing schedule from 06/10/26 through 06/23/26 revealed Staff E was the only staff member on day shift (7:00am - 7:00pm) on 06/20/26 and 06/21/26 for a total of 2-day shifts. Telephone interview with Staff E on 06/24/26 at 4:13pm revealed she had taken the CPR class "many years ago" and she knew her CPR certificate was "definitely expired." Refer to interview with the Manager on 06/25/26 at 12:50am. Refer to interview with the Regional Operations Director on 06/25/26 at 3:30pm. Refer to telephone interview with the contracted PCP on 06/25/26 at 12:41pm.	D 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 167	Continued From page 14 Interview with the Manager on 06/25/26 at 12:50pm revealed: -She was aware that the facility needed to have a staff member present in the facility 24/7 who was CPR certified. -She was not aware Staff C, and Staff E had expired CPR certificates. -She was aware Staff D did not have her CPR certificate. -The previous Administrator had been doing all the hiring and should have verified the staff's CPR was current or arranged for a CPR class as soon as possible. Interview with the Regional Operations Director on 06/25/26 at 3:30pm revealed: -She was aware that the facility needed to have a staff member present in the facility 24/7 who was CPR certified. -She was not aware they did not have CPR certified staff members on every shift. -Lack of staff had been causing a lot of issues for them. Telephone interview with the contracted PCP on 06/25/26 at 12:41pm revealed she was concerned the facility was operating without a CPR certified staff on all shifts. The facility failed to ensure Staff C, Staff D, and Staff E, had training on CPR and choking management in the last 24 months for 16 of 28 shifts from 06/10/26 - 06/23/26 resulting in no staff available to perform CPR in the event of a cardiac emergency. 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	D 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 167	Continued From page 15 accordance with G.S.131D-34 on 06/25/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 9, 2026.	D 167		
D 177	10A NCAC 13F .0601 (b) Management Of Facilities-General Administrato 10A NCAC 13F .0601 Management Of Facilities-General Administrator and Manager Responsibilities (b) An adult care home manager shall be responsible for carrying out the day-to-day operations and all required duties of an adult care home in the absence of an administrator. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the day-to-day operations and all required duties of an adult care home were carried out in the absence of an Administrator. The findings are: Review of the facility's census on 06/23/26	D 177		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 177	Continued From page 16 through 06/25/26 revealed there were ten residents residing at the facility. Interview with a resident during initial tour on 06/23/26 at 9:20am revealed the night shift staff administered his medications. Interview with a second resident during initial tour on 06/23/26 at 9:25am revealed the night shift staff administered his medications around 6:00am on 06/23/26. Interview with a third resident during initial tour on 06/23/26 at 9:32am revealed the night shift staff administered his medications before she left earlier that day. Review of the night staff personnel record revealed she was not qualified to administered medications. Review of the Manager's personnel record revealed she was not qualified to be the Manager. Interviews with a cook on 06/23/26 at 10:00 and 12:04pm revealed: -He did not have a list of the residents on a therapeutic diet. -He "just knew" who was on a diet because the Manager or former Administrator would inform him verbally. -There was one resident on a pureed diet, but he was not trained what that meant or how to prepare it. Interview with a second cook on 06/24/26 at 3:18pm revealed: -There was one resident at the facility who needed food chopped well due to a risk of choking.	D 177		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 177	Continued From page 17 -He learned how to prepare her food from the other cook who demonstrated how to chop the food. Interviews with the Manager on 06/23/26 at 6:00pm and 06/24/26 at 2:40pm and 3:51pm and 06/25/26 at 12:50pm revealed: -Two staff started administering medications after they took the 5-hour and 10-hour classes but prior to having their medication aide (MA) clinical skills validated. -The same two staff administered medications without supervision when they worked alone at night and on the weekends. -Two weeks ago, due to staff shortage, they changed from having two staff per shift to one staff per shift, not including the Manager or cook. -She was unable to schedule appointments the primary care provider (PCP) ordered because she was so busy with other duties. -She was aware there was not always a staff member present in the facility 24/7 who was cardio-pulmonary resuscitation (CPR) certified. Interview with the Regional Operations Director on 06/25/26 at 3:30pm revealed: -She was aware that the facility needed to have a staff member present in the facility 24/7 who was CPR certified. -She was not aware they did not have CPR certified staff members on every shift. -Lack of staff had been causing a lot of issues for them. Telephone interview with the contracted PCP on 06/25/26 at 12:41pm revealed she was concerned the facility was operating without a CPR certified staff on all shifts. Interview with a staff in training on 06/24/26 at	D 177		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 177	Continued From page 18 8:10am revealed: -She started working here about 2 or 3 weeks ago. -She usually worked 7:00am to 7:00pm but she worked 7:00pm to 7:00am starting 06/22/26 and was scheduled to work 24-hours straight from 7:00pm to 7:00pm starting 6/23/26. -She took the computer-based medication aide classes, but her MA clinical skills were not validated yet. -She was being trained as a PCA by the other PCA/MAs but had not had any formal training. -The Manager usually worked 9:00am to 5:00pm. Telephone interview with the Regional Operations Director on 06/24/26 at 8:37am and 06/25/26 at 3:29pm revealed: -The Manager was hired at the facility temporarily until a new Administrator could start in July 2026. -The Manager was previously the resident care director (RCC) and she had experience as a manager at a physician's office. -She thought the Manager could do all the necessary manager jobs temporarily since they had only 10 residents and were not at capacity. -PCAs could not work alone until they had been signed off by the consulting Registered Nurse (RN). -Staff who were recently hired should not work alone or administer medications until their MA clinical skills had been validated by the consulting RN. -The Manager and the previous Administrator were trying to cover shifts while staff were being trained. -They had "gaps" in the schedule due to staff "walk-outs". -The Manager was trying to "do it all and is afraid to say it is too much".	D 177		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 177	Continued From page 19 Interviews with the Manager on 06/24/26 at 9:32am and 1:40pm and on 06/25/26 at 12:45pm revealed: -She did not complete any pre-employment checks on a newly hired staff prior to them starting work because she was only one person and could not be here 24/7 and she needed someone to start working quickly since the facility had experienced so many staff resignations. -She was the RCC at the facility for about 4 months prior to becoming the Manager. -The RCC who trained her was "useless" and did not train her, so she had to learn everything herself. -She never took any management classes. -She was "thrown into" the Manager position when the previous Administrator walked out. -She was not able to "do it all" but she tried her best. -The Regional Operations Director explained the job duties to her, but she was unaware of how many problems and issues that were happening. Non-compliance was identified in the following rule areas: 1. Based on interviews and record reviews, the facility failed to ensure there was at least one staff on the premises at all times who completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) and choking management, including the Heimlich maneuver, for 3 or 5 sampled staff (Staff C, Staff D, and Staff E). Refer to Tag D167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)]. 2. Based on observations, interviews and record reviews the facility failed to serve a therapeutic diet as ordered to 1 of 4 sampled residents (#4)	D 177		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 177	Continued From page 20 who had a pureed diet with nectar thickened liquids. [Refer to Tag D310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type A1 Violation)]. 3. Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 3 sampled residents (Resident #3 and #1) were administered medications as ordered related to a medication used to treat a chronic lung disease (#3), a medication to treat hepatic encephalopathy (decline in brain function due to severe liver disease) (#3), and a medication to treat a vitamin deficiency (#1). [Refer to Tag D358 10A NCAC 1004(a) 13F Medication Administration (Type B Violation)]. The facility failed to ensure the day-to-day management and operations of the facility were carried out which compromised the care of all residents, including the facility being managed by an unqualified Manager after the Administrator quit abruptly, medications being administered by untrained staff; a resident ordered a pureed diet with nectar thickened liquids receiving a chopped diet with thin liquids and staffing the facility 14 times on night shift and twice on day shift with a single employee who was not CPR trained. This failure resulted in serious neglect and constitutes a Type A1 Violation. The facility provided a Plan of Protection in accordance with G.S. 131 D-34 on June 25, 2026, for this violation.	D 177		
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Facility & 10A NCAC 13F .0704 Resident Contract,	D 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 248	Continued From page 21 Information On Facility, And Resident Register (b) The administrator or their management designee and the resident or the resident's representative shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following: (1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address; (2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status; (3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests; (4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail; (5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D-4.8; and (6) resident's consent including a signature confirming the review and receipt of information contained in the form. The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf at no charge. The facility may use a resident information form other than the Resident Register as long as it contains the same information as	D 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 248	Continued From page 22 the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Resident Register was completed, signed, and dated within 72 hours of admission to the facility for 4 of 4 residents (Residents #1, #3, #4 and #5). The findings are: 1. Review of Resident #1's undated FL2 revealed diagnoses included diabetes, chronic kidney disease, gait abnormality, cognitive communication deficit and ophthalmic complication. Review of Resident #1's record revealed a Resident Register was not available to review. Refer to interview with the Manager on 06/25/26 at 12:50pm. Refer to interview with the Regional Operations Director on 06/25/26 at 3:30pm. 2. Review of Resident #4's current FL2 dated 05/08/26 revealed diagnoses included recurrent aspiration events, esophageal food bolus, dementia, gastro-esophageal reflux disease (GERD).	D 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 248	Continued From page 23 Review of Resident #4's record revealed a Resident Register was not available to review. Refer to interview with the Manager on 06/25/26 at 12:50pm. Refer to interview with the Regional Operations Director on 06/25/26 at 3:30pm. 3. Review of Resident #3's current FL2 dated 06/17/26 revealed diagnoses included chronic lung disease and gait and mobility issues. Review of Resident #3's Resident Register revealed: -Resident #3's admission date was 06/09/26. -The Resident Register was signed by Resident #3 on "07/09/26." -The Resident Register was not signed and dated by the Administrator or Manager. Refer to interview with the Manager on 06/25/26 at 12:50pm. Refer to interview with the Regional Operations Director on 06/25/26 at 3:30pm. 4. Review of Resident #5's current FL2 dated 02/27/26 revealed diagnoses included mood disorder, lower back pain, anemia, high blood pressure and gastric reflux disease. Review of Resident #5's Resident Register revealed: -Resident #5's admission date was 03/04/26. -The Resident Register was signed and dated by Resident #5's Power of Attorney (POA) on 03/10/26. -The Resident Register was signed and dated by the Administrator on 03/10/26.	D 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 248	Continued From page 24 Refer to interview with the Manager on 06/25/26 at 12:50pm. Refer to interview with the Regional Operations Director on 06/25/26 at 3:30pm. Interview with the Manager on 06/25/26 at 12:50pm revealed: -She was aware the Resident Register was supposed to be completed, signed and dated within 72 hours of a residents' admission. -The previous Administrator was responsible for ensuring the Resident Registers were completed. Interview with the Regional Operations Director on 06/25/26 at 3:30pm revealed: -She thought the previous Administrator had removed documents from the facility before she quit. -She was not aware there was a problem with the Resident Registers not being completed fully within 72 hours of resident admissions.	D 248		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure referral and follow-up to meet the acute and routine health care needs for 2 of 5 sampled residents (# 1 & #4) related to a referral for a Speech Language Pathology (SLP) swallowing evaluation (#4) and an eye examination (#1).	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 273	Continued From page 25 The findings are: 1. Review of Resident #4's current FL2 dated 05/08/26 revealed diagnoses included recurrent aspiration events, esophageal food bolus, dementia, gastro-esophageal reflux disease (GERD). Review of Resident #4's care plan dated 04/23/26 revealed Resident #4 needed supervision at meals due to choking on food and drink. Review of Resident #4's hospital discharge summary dated 05/08/26 revealed: -Resident #4 was admitted to the hospital on 05/07/26 due to a food bolus in the esophagus requiring removal under anesthesia. -She was discharged back to the facility on a pureed diet. Review of Resident #4's physician's orders dated 05/11/26 revealed: -Pureed diet with nectar thickened liquids. -SLP evaluation to re-evaluate swallowing safety. Review of Resident #4's Accident & Incident Report dated 05/12/26 revealed: -She choked during medication administration and required the Heimlich maneuver to clear her airway. -There was no documentation the primary care provider (PCP) or the guardian were notified. Interview with the Manager on 06/25/26 at 12:45pm revealed: -Resident #4 had a history of choking and had to have food removed from her esophagus at the hospital. -The previous Administrator did not tell her an	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 273	Continued From page 26 SLP evaluation was ordered after the hospitalization. Telephone interview with Resident #4's PCP on 06/25/26 at 12:14pm revealed: -She ordered an SLP evaluation to re-evaluate Resident #4's swallowing ability because she had a history of choking and recently started a pureed diet with thickened liquids after a hospitalization related to choking. -She sent the SLP evaluation order directly to the home health agency that provided the services to the facility. -She expected the Administrator to follow-up to be sure the evaluation was completed and inform her if the SLP did not complete the evaluation. -Resident #4 was at risk of aspiration, pneumonia and another hospitalization if she choked again. Interview with the Regional Director of Operations on 06/25/26 at 3:29pm revealed: -The previous Administrator informed her Resident #4 was having difficulty swallowing safely. -She was not aware an SLP evaluation was ordered for Resident #4. -The previous Administrator was responsible for ensuring health care referrals were completed. 2. Review of Resident #1's undated FL2 revealed diagnoses included diabetes, chronic kidney disease, gait abnormality, cognitive communication deficit and ophthalmic complication. Review of resident #1's physician's orders dated 05/04/26 revealed an order for a routine eye examination. Interview with the Manager on 06/25/26 at	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 273	Continued From page 27 12:45pm revealed: -The previous Administrator was responsible for scheduling appointments. -She learned last week Resident #1 had an eye examination ordered when the facility's PCP gave her a list of referrals that were not completed by the previous Administrator. Telephone interview with Resident #4's PCP on 06/25/26 at 12:14pm revealed: -She ordered a routine eye examination for Resident #1 because he had macular degeneration related to diabetes and needed a yearly eye examination. -She expected the appointment to be scheduled by now but she did not expect it to be completed by now because it usually took a year to get an appointment with an eye physician. Interview with the Regional Director of Operations on 06/25/26 at 3:29pm revealed: -She was not aware an eye examination was ordered for Resident #1. -The previous Administrator was responsible for ensuring health care referrals were completed.	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 28 This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to have a matching therapeutic diet menu for 1 of 4 sampled residents (#4) with a physician-ordered therapeutic diet for guidance of food service staff related to a pureed diet with nectar thickened liquids. The findings are: Observation of the kitchen during initial tour on 06/23/26 at 10:00am revealed therapeutic diet menus were not available for guidance. Review of Resident #4's current FL2 dated 05/08/26 revealed diagnoses included recurrent aspiration events, esophageal food bolus, dementia, gastro-esophageal reflux disease (GERD). Review of Resident #4's physician's orders dated 05/11/26 revealed a pureed diet with nectar thickened liquids. Interview with a cook on 06/23/26 at 10:00am revealed: -He did not have a menu for a pureed diet. -He used the regular menu as guidance for everyones diet. Interview with a second cook on 06/24/26 at 3:18pm revealed Resident #4 was on a chopped diet and he used the regular menu as guidance. Interview with the Manager on 06/23/26 at 12:25pm, 06/24/26 at 2:40pm and 06/25/26	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 29 2:55pm revealed: -The facility did not have menu for therapeutic diets, only the regular menu. -She did not know what information the dietary staff were supposed to have in the kitchen. -The dietary staff served all residents the same foods from the regular menu. Interview with the Regional Operations Director on 06/25/26 at 3:29pm revealed the facility paid for therapeutic diet menus and she did not know why they were not available in the kitchen.	D 296		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff related to 4 of 4 sampled residents (#1, #2, #3, & #4) who had a pureed diet with thickened liquids (#4) and a carbohydrate controlled diet (#1, #2, #3).	D 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 309	Continued From page 30 The findings are: Observation of the kitchen during initial tour on 06/23/26 at 10:00am revealed a list of residents ordered therapeutic diets was not available for staff guidance. Interview with the cook on 06/23/26 at 10:00am revealed: -He had 2 residents on carbohydrate controlled diets and one resident on a pureed diet. -He did not need a list of residents ordered therapeutic diets to refer to because he knew everyones diet. -The Manager or the previous Administrator informed him when a resident was ordered a therapeutic diet. Interview with a second cook on 06/24/26 at 3:18pm revealed: -The previous Administrator kept a list of residents who received therapeutic diets posted in the kitchen for staff to reference. -He did not know why or when it was removed. -There were two residents on a diabetic diet and one resident who was on a chopped diet. 1. Review of Resident #4's current FL2 dated 05/08/26 revealed diagnoses included recurrent aspiration events, esophageal food bolus, dementia, gastro-esophageal reflux disease (GERD). Review of Resident #4's 05/11/26 physician's orders revealed a pureed diet with nectar thick liquids. Interview with a cook on 06/23/26 at 12:04pm and 2:38pm revealed the previous Administrator informed him Resident #4 was ordered a pureed	D 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 309	Continued From page 31 diet. Refer to interview with the Manager on 06/23/26 at 12:25pm. 2. Review of Resident #1's undated FL2 revealed diagnoses included diabetes, chronic kidney disease, gait abnormality, cognitive communication deficit and ophthalmic complication. Review of Resident #1's 05/04/26 physician's orders revealed a carbohydrate controlled diet. Interview with the cook on 06/23/26 at 10:00am revealed Resident #1 was on a carbohydrate controlled diet. Refer to interview with the Manager on 06/23/26 at 12:25pm. 3. Review of Resident #2's current FL2 dated 04/07/26 revealed: -Diagnoses included vascular dementia and diabetes. -A carbohydrate controlled diet. Interview with the cook on 06/23/26 at 10:00am revealed Resident #2 was on a carbohydrate controlled diet. Refer to interview with the Manager on 06/23/26 at 12:25pm. 4. Review of Resident #5's current FL2 dated 4/23/26 revealed: -Diagnoses included low vitamin D level, anemia, gastro-esophageal reflux disease (GERD). -A carbohydrate controlled diet.	D 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 309	Continued From page 32 Refer to interview with the Manager on 06/23/26 at 12:25pm. _____ Interview with the Manager on 06/23/26 at 12:25pm revealed: -The previous Administrator was in charge of the kitchen and provided staff the information they needed. -She did not know what information the dietary staff were supposed to have in the kitchen. -She knew there were residents with therapeutic diets and she thought the cooks knew what the orders were.	D 309		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews the facility failed to serve a therapeutic diet as ordered to 1 of 4 sampled residents (#4) who had a pureed diet with nectar thickened liquids. The findings are: Review of Resident #4's current FL2 dated 05/08/26 revealed diagnoses included recurrent aspiration events, esophageal food bolus,	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 310	Continued From page 33 dementia and gastro-esophageal reflux disease (GERD). Review of Resident #4's care plan dated 04/23/26 revealed Resident #4 needed supervision at meals due to choking on food and drink. Review of Resident #4's hospital discharge summary dated 05/08/26 revealed: -Resident #4 was admitted to the hospital on 05/07/26 due to a food bolus in the esophagus requiring removal under anesthesia. -She was discharged on a pureed diet. Review of Resident #4's physician's orders dated 05/11/26 revealed a pureed diet with nectar thickened liquids. Review of the facility's menus revealed a menu for a pureed diet was not available. Observation of the kitchen on 06/24/26 at 4:44pm revealed there was no thickened beverages in the refrigerator and no powder for thickening in dry food storage or elsewhere in the kitchen. Observation of the lunch meal service on 06/23/26 at 12:00pm revealed: -Resident #4 was served a bowl of chopped ramen noodles and vanilla pudding and drinking an unthickened beverage. -A personal care aide (PCA) removed the bowl of ramen noodles at the request of the surveyor and took it to the cook to be pureed. -The cook returned the bowl of noodles to Resident #4 but it was still not pureed so the surveyor requested he puree the noodles to a smooth pudding-like consistency. Observation of the dinner meal service on	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 310	Continued From page 34 06/24/26 at 5:15pm revealed: -Resident #4 was served a bowl of chopped chicken, noodles and mixed vegetables and a bowl of vanilla pudding and drinking an unthickened beverage. -About 75% of the meal was consumed prior to the observation. Observation of the breakfast meal service on 06/25/26 at 8:21am revealed she was eating scrambled eggs, oatmeal and ground sausage and drinking nectar thickened juice and nectar thickened coffee. Interview with a cook on 06/23/26 at 12:04pm and 2:38pm and 06/25/26 at 8:26am revealed: -He did not know the meaning of a pureed diet because he was not trained how to prepare that diet. -He did not know pureed food needed to be as smooth as pudding. -He usually "smashed" the foods he served to Resident #4. -He crushed Resident #4's ramen noodles because he thought that was an appropriate texture for her to eat. -He generally did not use the regular menu to prepare Resident #4's foods because he did not think she would like those foods crushed up with liquids. -The previous Administrator informed him Resident #4 was ordered a pureed diet and he needed to blend the food; but she did not give any other guidance. -There was confusion about Resident #4's diet on 06/23/26 and he still did not know today (06/25/26) what her diet was supposed to be. -There was a new immersion blender that was put in the kitchen on 06/24/26 when he was not working.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 310	Continued From page 35 Interview with a second cook on 06/24/26 at 3:18pm, 4:46pm and 5:15pm revealed: -Resident #4 was on a chopped diet. -He used the regular menu as guidance and chopped up those foods except for bread which he never gave to her. -He was not trained how to prepare Resident #4's food; he just learned from the other cook who demonstrated how he prepared it. -Resident #4 was eating the same meal for supper that he served her at lunch because she "did well and liked it". -He had no way to puree Resident #4's food as he only had a small food chopper. -He did not think they had thickened liquids for residents and was not sure what thickened liquids were. -He had never heard of thickened liquids so he was sure they had no residents with an order for it. Interview with a PCA on 06/23/26 at 12:06pm and on 06/24/26 at 4:55pm revealed: -Resident #4 was ordered a pureed diet about 2 weeks ago. -She was usually served crushed ramen noodles and ground meats in liquids. -She did not know pureed food needed to be as smooth as pudding. -She thought pureed meant "liquidy and really small". -The previous Administrator told her Resident #4's insurance would not pay for her thickened liquids because it could be purchased over the counter. -The previous Administrator sent one of the cooks to a local business to purchase the thickened liquid beverage or powder. -The cook was unable to find the thickened liquid	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 310	Continued From page 36	D 310		

beverage or powder and returned to the facility without it.
-The previous Administrator told her not to worry about it and not to say anything to anyone about it because Resident #4 was doing just fine wihout the thickened liquids.

Interview with the Manager on 06/23/26 at 12:25pm and 06/24/26 at 2:40pm and on 06/24/26 at 4:40pm revealed:
-Resident #4 was ordered a pureed diet about 2 months ago.
-The previous Administrator was responsible for training the cooks because she was in charge of the kitchen staff.
-The facility did not have a menu for a pureed diet for kitchen staff to use as guidance.
-The previous Administrator told all the staff ramen noodles were "safe" and to give her that for her meals.
-She did not know Resident #4 was ordered nectar thickened liquids.

Interview with the Manager on 06/25/26 at 2:55pm revealed:
-Resident #4 was served all her food chopped and she thought that was what her diet order was supposed to be.
-Diet orders were communicated verbally to staff by the prior Administrator.

Review of Resident #4's Accident & Incident Report dated 05/12/26 revealed:
-Resident #4 choked at 8:43am during medication administration on pills crushed and mixed into water.
-The medication aide (MA) administering medications to Resident #4 was documented as the Manager.
-The Manager performed the Heimlich maneuver

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 310	Continued From page 37 to clear her airway. -The previous Administrator was notified at 9:00am. -There was no documentation the primary care provider was notified. -There was no documentation the guardian was notified. Telephone interview with Resident #4's guardian representative on 06/24/26 at 4:42pm revealed: -She was notified by the previous Administrator on 05/12/26 that Resident #4 was ordered a pureed diet with nectar thickened liquids. -She did not know when or if the diet was started. -She did not think Resident #4 had any additional choking incidents since she was at the hospital on 05/07/26. Telephone interview with Resident #4's primary care provider (PCP) on 06/25/26 at 12:14pm revealed: -She was made aware on 06/24/26 that staff were not following Resident #4's diet order because there was confusion about what it was supposed to be. -Resident #4 was ordered a pureed diet with nectar thickened liquids due to a swallowing difficulty that put her at risk of choking. -She expected them to follow the diet order that she wrote and if they did not Resident #4 was at risk of choking again and aspirating, possibly developing pneumonia and needing to be hospitalized. Interview with the Regional Operations Director on 06/25/26 at 3:29pm revealed: -She thought dietary staff were serving diets as ordered. -It was not communicated correctly by the previous Administrator when Resident #4 was	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 310	Continued From page 38 ordered a pureed diet with nectar thickened liquids. Based on observation, interview and record review Resident #4 was not interviewable. The facility failed to serve Resident #4, who had a recent history of choking and needed to have food removed from her esophagus under anesthesia on 05/07/26, a pureed diet with nectar thickened liquids. It was not communicated to staff that Resident #4 was ordered a pureed diet with nectar thickened liquids on 05/11/26 nor were staff trained how to prepare her food and on 05/12/26 she choked again during medication administration and required the Heimlich maneuver. This failure resulted in serious neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on June 25, 2026. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 25, 2026.	D 310		
D 316	10A NCAC 13F .0905 (c) Activities Program 10A NCAC 13F .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be	D 316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 316	Continued From page 39 posted in a location accessible to residents by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are, supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a monthly calendar of planned activities was developed and posted in the facility on the first day of the calendar month. The findings are: Observation during initial tour on 06/23/26 and throughout the survey on 06/24/26 and 06/25/26 revealed there was not an activity calendar for June 2026 posted in the facility. Interview with a resident on 06/23/26 at 9:10am revealed there was not a June 2026 activity calendar posted.	D 316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 316	Continued From page 40 Interview with another resident on 06/23/26 at 9:45am revealed staff had not posted a June 2026 activity calendar. Interview with the Manager on 06/25/26 at 12:50pm revealed: -The previous Administrator chose to develop the monthly activity calendars. -The previous Administrator left abruptly the second week of June 2026 before she posted the June 2026 activity calendar. -She was a certified Activity Director. Interview with the Regional Operations Director on 06/25/26 at 3:30pm revealed: -She was not aware there was not a June 2026 calendar posted in the facility. -There should be a monthly calendar posted in the facility by the first of every month. -The previous Administrator had been responsible for completing and posting the monthly activity calendar.	D 316		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a minimum of 14 hours of group activities were provided each week for the	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 317	Continued From page 41 residents. The findings are: Observations at the facility on 06/23/26 revealed there was an activity that consisted of blowing bubbles outside and dancing to music from 4:00pm to 5:00pm, which was not posted on a calendar. Observations at the facility on 06/24/26 revealed no activities occurred. Observations at the facility on 06/25/26 revealed no activities occurred. Interview with a resident on 06/23/26 at 9:10am revealed: -They did not have a current monthly calendar to know what activities were available. -The activities were "kind of slim." -There was not a lot to do. -They never had 14 hours of activities or more. Interview with a second resident on 06/23/26 at 9:25am revealed: -There were not a lot of activities offered to the residents. -She wished they had more group activities available. Interview with a third resident on 06/23/26 at 9:35am revealed he had nothing to do but watch television. Interview with a personal care aide (PCA) on 06/23/26 at 3:40pm revealed: -There was not a current June 2026 activity calendar to choose activities from. -Sometimes she would paint with the residents	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 317	Continued From page 42 and throw balls back and forth with them. -She had not been able to perform any activities with the residents on 06/23/26 because her extra time had been spent with a resident that had dementia and was also a wanderer. Interview with the Manager on 06/25/26 at 12:50pm revealed: -Since there was not a calendar posted for June 2026 activities were being done randomly by staff. -The PCAs and the medication aides (MAs) were supposed to conduct activities when they were done with their job responsibilities. -Activities were being done more often when they had more staff during the day, but now there was only one MA per shift who also performed PCA duties. Interview with the Regional Operations Director on 06/25/26 at 3:30pm revealed: -There had been more regular activities until the previous Administrator left. -Staffing had been challenging since they had lost several staff at the same time. -She was aware they were supposed to providing 14 hours of activities per week.	D 317		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so.	D 319		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 319	Continued From page 43 This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure all residents were offered at least one outing every other month. The findings are: Review of the Assisted Living Residency agreement regarding "Planned Activities" revealed facility staff will assist interested resident groups in planning social and recreational activities, both at and away from the community. Observation of the facility on 06/23/26 at 9:15am revealed: -There was not a June 2026 calendar available for review. -There was a May 2026 calendar available for review. -On the May 2026 calendar, there were no outings scheduled. Interviews with several residents on 06/24/26 from 11:36am through 11:51am revealed: -The residents had not been on an outing since the facility reopened in March 2026. -One of the residents had only been out of the facility with family. -A resident thought it would be nice to go on outings but did not think there was enough staff to take them. -There were no outings being offered. Interview with a personal care aide (PCA) on 06/24/26 at 3:40pm revealed: -The facility had a van, but it had not worked since the facility reopened.	D 319		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 319	Continued From page 44 -She was not aware of any outings that had been offered to the residents since they reopened. Interview with the Manager on 06/25/26 at 12:50pm revealed: -She was aware there was supposed to be an outing every other month. -The facility van had been inoperable since the facility reopened in March 2026. -The previous Administrator was responsible for developing the monthly activity calendar. Interview with the Regional Operations Director on 06/25/26 at 3:30pm revealed she was not aware the residents were not participating in an outing every other month.	D 319		
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: (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: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 3 sampled residents (Resident #3 and #1) were administered medications as ordered related to a medication used to treat a chronic lung disease (#3), a medication to treat hepatic	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 encephalopathy (decline in brain function due to severe liver disease) (#3), and a medication to treat a vitamin deficiency (#1). The findings are: Review of the facility's Medication Management Policy dated 04/2024 revealed: -The facility is responsible for obtaining newly ordered medication or refills for medications and treatment orders. -Medication refills will be obtained in a timely manner to ensure residents have physician ordered medication available. 1. Review of Resident #3's current FL2 dated 06/17/26 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD) and abnormal gait and mobility. -There was an order for xifaxan (used to treat hepatic encephalopathy) 550mg twice a day. -There was an order for fluticasone-salmeterol (long-acting inhaled medication used to treat COPD) 100-50 inhale 1 puff twice a day. a. Review of Resident #3's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for fluticasone-salmeterol 100-50 inhale 1 puff twice a day at 7:00am and 7:00pm. -The fluticasone-salmeterol was documented as administered for 2 of 27 opportunities. -The fluticasone-salmeterol was not documented as administered for 8 opportunities due to "medication out of stock - reordered." -The fluticasone-salmeterol was not documented as administered for 17 opportunities due to "requires approval or prior authorization."	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 46 -The fluticasone-salmeterol was not documented as administered for 2 opportunities with no reason given. Observation of Resident #3's medications on hand on 06/23/26 at 3:05pm revealed there was no fluticasone-salmeterol 100/50 available on the medication cart. Interview with a pharmacy representative on 06/23/26 at 2:13pm revealed: -On 06/09/26 the pharmacy received an order for fluticasone-salmeterol for Resident #3. -The fluticasone-salmeterol was not covered through Resident #3's insurance. -A member of the billing department for the pharmacy notified the facility on 06/09/26 that Resident #3's insurance did not cover the fluticasone-salmeterol and gave two alternatives and requested a response from the facility. -A response from the facility was never received so Resident #3 never received the fluticasone-salmeterol or one of the alternate medications. Interview with Resident #1 on 06/25/26 at 9:17am revealed: -He needed his fluticasone-salmeterol. -One of the staff told him on 06/09/26 that his fluticasone-salmeterol was not with his medications and there was none available to administer to him. -The fluticasone-salmeterol worked best, but he had a different inhaler he kept in his room that he was using several times a day until the fluticasone-salmeterol was delivered. -His shortness of breath occurred anytime day or night, and he needed his inhaler to resolve his shortness of breath.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 47 Telephone interview with the facility's primary care provider (PCP) on 06/25/26 at 12:25pm revealed: -She had not been made aware his fluticasone-salmeterol was not available to him. -She was not aware he had gone two weeks without his fluticasone salmeterol. -If she had been aware his fluticasone salmeterol was not available, she could have changed it to another medication. -Without his fluticasone salmeterol he could have had increased shortness of breath, possible coughing and wheezing. Interview with the Manager on 06/25/26 at 12:50pm revealed: -She had been made aware by the pharmacy billing department on 06/09/26 that Resident #3's fluticasone salmeterol would not be covered by insurance. -She sent a fax to the pharmacy billing department on 06/10/26 making them aware he would not be able to pay out of pocket for this medication. -She notified the PCP they needed to complete a medication change request to prevent further delay in Resident #3's treatment for his COPD. -She did not know if the medication change had been completed by the PCP. b. Review of Resident #3's June 2026 eMAR revealed: -There was an entry for xifaxan 550 mg twice a day at 7:00am and 7:00pm. -The xifaxin was documented as administered 16 of 29 opportunities. -The xifaxan was documented as not administered from 7:00pm on 06/17/26 through 7:00pm on 06/23/26, for a total of 13 opportunities. -The xifaxan was documented as not	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 48 administered for 9 opportunities due to "medication out of stock-reordered." -The xifaxan was documented as not administered for 2 opportunities due to "requires approval or prior authorization." -The xifaxan was documented as not administered for 2 opportunities with no reason given. Observation of Resident #3's medications on hand on 06/23/26 at 3:05pm revealed there was no xifaxan 500mg available on the medication cart. Interview with a pharmacy representative on 06/23/26 at 2:13pm revealed: -On 06/09/26 the pharmacy received an order xifaxan 550mg twice a day for Resident #3. -The order was rejected through their billing department because the order had been dispensed through another pharmacy on 06/02/26. -The facility sent a re-order request on 06/18/26 for the xifaxan to be sent monthly in the cycle batch from the pharmacy. -The xifaxan was now scheduled to be sent to the facility once a month in the monthly cycle batch beginning 06/30/26. -Xifaxan was not requested from the facility to be received earlier than 06/30/26. Telephone interview with the facility's primary care provider (PCP) on 06/25/26 at 12:25pm revealed: -She had not been made aware Resident #3 had missed 13 doses of his xifaxan. -She should have been notified by facility staff that Resident #3 had missed multiple doses of his xifaxin. -Without the xifaxan, Resident #3 could have altered mental status and a recurrence of hepatic	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 49 encephalopathy. Interview with the Manager on 06/25/26 at 12:50pm revealed: -She was waiting on Resident #3's xifaxan from the pharmacy. -She was not aware the pharmacy had prepared to send it in the monthly batch at the end of the month before she reordered it on 06/24/25. 2. Review of Resident #1's undated FL2 revealed diagnoses included diabetes, chronic kidney disease, gait abnormality, cognitive communication deficit and ophthalmic complication. Review of Resident #1's physicians orders dated 05/11/26 revealed Vitamin D 1.25mg weekly. Review of Resident #1``s May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D 1.25mg weekly. -Vitamin D 1.25mg was administered on 05/18/26. -Vitamin D 1.25mg was not administered on 05/25/26 due to medication out of stock-reordered.  Review of Resident #1``s June 2026 eMAR revealed: -There was an entry for Vitamin D 1.25mg weekly. -Resident #1 was out of the facility from 06/01/26 after noon until 06/08/26 at 11:47am. -Vitamin D 1.25mg was not administered on 06/01/26 due to medication out of stock-reordered. -Vitamin D 1.25mg was administered on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 50 06/15/26. -Vitamin D 1.25mg was not administered on 06/22/26 due to medication out of stock-reordered. Observation of Resident #1's medications on hand on 06/23/26 at 4:43 revealed Vitamin D 1.25mg was not available. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/25/26 at 9:04am revealed: -The pharmacy received the order for Vitamin D 1.25mg weekly on 05/11/26. -They dispensed 3 capsules on 05/11/26, enough for him to receive it weekly through the end of May 2026. -They dispensed 4 more capsules on 05/26/26, but the facility returned them. -She could find no documentation that a request to refill Vitamin D had been sent on 05/25/26, 06/01/26 or 06/22/26. -They received a call from the facility on 06/24/26 requesting a refill, so they dispensed one capsule that evening. -Vitamin D 1.25mg was scheduled to be dispensed again later in the month with the routine cycle fill for July 2026 administration. Telephone interview with Resident #1's primary care provider (PCP) on 06/25/26 at 12:14pm revealed: -Resident #1 was ordered Vitamin D weekly due to a low Vitamin D level on 05/07/26. -She was not informed he was not receiving it as ordered. -Resident #1's Vitamin D level would continue to decline and may cause fatigue if it was not administered as ordered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 51 Interview with the Manager on 06/25/26 at 11:43am revealed: -She did not know why the Vitamin D was returned to the pharmacy because she was not working on the medication cart during that time. -When she worked on the medication cart she completed cart audits and ensured all medications were available but the previous Administrator did not complete cart audits. The facility failed to ensure medications to treat COPD and hepatic encephalopathy for Resident #3 and medication to treat a vitamin deficiency for Resident #1 were administered as ordered. This failure put Resident #3 at risk for shortness of breath, coughing, wheezing, altered mental status, and a recurrence of hepatic encephalopathy and put Resident #1 at risk for fatigue due to a further decline in Vitamin D level. 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 June 25, 2026 for this Type B Violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 9, 2026.	D 358		

HIGHLANDS SENIOR LIVING – FOREST CITY

PLAN OF CORRECTION

Facility: Highlands Senior Living

Address: 2270 Oakland Road, Forest City, NC 28043

Licensure Number: HAL 081-054

ASPEN Event ID: F7G211

Survey Completed: June 25, 2026

This draft now includes all 16 citations from the June 25, 2026 survey, including the previously submitted Type A1 Plans of Correction for D177 and D310.

Tag D124

10A NCAC 13F .0402 – Qualifications of Manager

Corrective Action Taken

The facility reviewed the qualifications and personnel documentation of the individual serving as Manager during the Administrator's absence. Documentation verifying completion of the required continuing education was located and placed in the personnel file. Effective July 13, 2026, a licensed North Carolina Adult Care Home Administrator assumed responsibility for the facility.

How Other Residents/Staff Were Protected

Management personnel files were reviewed to verify that individuals designated to act in a management capacity meet applicable qualification and documentation requirements.

Systemic Changes Implemented

A standardized management personnel-file checklist has been implemented to verify required qualifications, licenses/certifications, experience, and continuing education upon designation and annually thereafter.

Monitoring

The Administrator or designee will audit management personnel documentation monthly for three months and quarterly thereafter. Any deficiency identified will be corrected immediately.

Completion Date: ___July 13, 2026_____

Tag D125

10A NCAC 13F .0403(a) – Qualifications of Medication Staff

Corrective Action Taken

The facility reviewed Medication Aide qualifications and competency documentation. Medication Aide Skills Validation appointments were scheduled with the facility's Pharmacy Registered Nurse for employees requiring competency validation. No employee will independently administer medications until all state-required Medication Aide training, testing, and competency requirements have been completed and documented.

How Other Residents/Staff Were Protected

A 100% audit of staff who administer medications was completed to verify required Medication Aide training, testing, and clinical skills competency documentation.

Systemic Changes Implemented

Medication Aide qualification verification has been incorporated into the pre-employment/orientation checklist. Staff may not be assigned independent medication-administration duties until the Administrator or designee verifies required documentation.

Monitoring

The Administrator or designee will audit Medication Aide qualification and competency records weekly for three months and thereafter as part of routine personnel-file review. Any deficiency will be corrected before the employee administers medications independently.

Completion Date: _____August 06, 2026_____

Tag D139

10A NCAC 13F .0407(a)(7) – Other Staff Qualifications / Criminal Background Check

Corrective Action Taken

The personnel file identified during the survey was reviewed and the required criminal background-check documentation was obtained/completed as applicable. The employee's file was updated with the required documentation.

How Other Residents/Staff Were Protected

A 100% audit of active personnel files was completed to verify criminal background-check documentation was present as required.

Systemic Changes Implemented

The facility implemented a standardized pre-employment checklist requiring verification of the criminal background check before an employee is permitted to work when required by regulation.

Monitoring

The Administrator or designee will audit personnel files weekly for three months for compliance with pre-employment requirements. Any missing documentation will be addressed immediately.

Completion Date: ___July 31, 2026_____

Tag D140

10A NCAC 13F .0407(a)(8) – Other Staff Qualifications / Controlled Substance Screening

Corrective Action Taken

The personnel file identified during the survey was reviewed and the required consent and controlled-substance screening documentation was obtained/completed as applicable and maintained in the personnel file.

How Other Residents/Staff Were Protected

A 100% audit of active personnel files was completed to verify required controlled-substance screening and consent documentation.

Systemic Changes Implemented

Controlled-substance screening and signed consent have been added to the facility's standardized pre-employment checklist and must be verified before an employee begins work when required.

Monitoring

The Administrator or designee will audit personnel files weekly for three months for compliance with pre-employment screening requirements. Deficiencies will be corrected immediately.

Completion Date: __July 31, 2026_____

Tag D151

10A NCAC 13F .0501(c) – Personal Care Training

Corrective Action Taken

The facility reviewed the training status of staff performing personal care. Any employee who had not completed required personal-care training and competency requirements was removed from independent personal-care duties until the required training, supervision, and competency documentation was completed.

How Other Residents/Staff Were Protected

A 100% audit of direct-care staff training records was completed to verify required personal-care training and competency documentation.

Systemic Changes Implemented

The orientation process now includes verification of personal-care training requirements before staff are assigned independent resident-care duties. Employees still in training will work only within the scope permitted while required training and supervision are completed.

Monitoring

The Administrator or designee will audit direct-care training records weekly for three months and during onboarding of each new direct-care employee.

Completion Date: _____August 6, 2026_____

Tag D167

10A NCAC 13F .0507 – Training on CPR and Choking

Corrective Action Taken

CPR certification classes were scheduled through the facility's Pharmacy Registered Nurse for existing employees and new hires requiring certification. Staffing schedules were reviewed to ensure required trained coverage is maintained on each shift.

How Other Residents/Staff Were Protected

A 100% audit of employee CPR/choking-response training documentation was completed and the staffing schedule was reviewed for required coverage.

Systemic Changes Implemented

The facility implemented a CPR certification tracking system to monitor expiration dates and ensure appropriately trained staff are scheduled on every shift.

Monitoring

The Administrator or designee will review CPR certification status and staffing schedules daily for 30 days and weekly thereafter for three months. Expiring certifications will be addressed before lapse.

Completion Date: __August 12, 2026_____

Tag D177

10A NCAC 13F .0601(b) - Administrator and Manager Responsibilities - TYPE A1 VIOLATION

Corrective Action Taken

- The facility acknowledges that deficiencies in management oversight during the leadership transition resulted in noncompliance with multiple regulatory requirements. Since the survey, the facility has established stable leadership under a licensed Administrator and implemented the corrective measures outlined below to ensure sustained compliance.
- Effective July 13, 2026, the facility hired a licensed North Carolina Adult Care Home Administrator who assumed responsibility for the day-to-day operation of the facility, regulatory compliance, resident care oversight, personnel management, quality assurance, and implementation of physician orders.
- Following the survey, the Administrator conducted a comprehensive review of facility operations to address each area identified during the survey.
- A review of Medication Aide qualifications was completed. Medication Aide Skills Validation appointments were scheduled with the facility's Pharmacy Registered Nurse for all existing employees and newly hired staff requiring competency validation. No employee will administer medications independently until all state-required Medication Aide training and competency requirements have been completed and documented.
- The personnel file of the interim manager identified during the survey was reviewed. Documentation verifying completion of the required twelve (12) hours of continuing education was located and placed in the personnel file, confirming the individual met the continuing education requirement.
- The facility completed a comprehensive review of dietary services. The facility enrolled in the Grove Menu Program, a dietary management system developed by registered dietitians that provides regular and therapeutic menus, standardized recipes, master diet rosters, tray cards, production records, and other dietary compliance tools. On June 25, 2026, the physician practice was contacted and all resident diet orders were verified. A current Master Diet Roster was established to accurately identify residents receiving therapeutic diets and is maintained in the kitchen for dietary staff reference.
- On June 25, 2026, all dietary staff completed therapeutic diet education utilizing the North Carolina Division of Health Service Regulation (DHSR) training materials, including Instructional Training Video 1068, Section 5 - Therapeutic Diets, review of the DHSR Therapeutic Diet Manual, and successful completion of the associated knowledge assessment. Therapeutic diet education has been incorporated into orientation for all newly hired dietary employees, and continuing education will be provided routinely to maintain competency.
- To improve continuity of resident medical care following admission, the facility implemented a Pre-Admission Appointment Tracking Addendum to the Residency Agreement. Any physician appointments, specialist appointments, or diagnostic services scheduled prior to admission are documented during the admission process and tracked by the Clinical Coordinator to ensure timely follow-up after admission.
- CPR certification classes were scheduled through the facility's Pharmacy Registered Nurse for all existing employees and new hires requiring certification. The facility implemented a CPR tracking system to monitor certification expiration dates and ensure CPR-certified staff are scheduled on every shift.
- A comprehensive audit of personnel files was completed. Any missing pre-employment requirements, including criminal background checks, controlled substance screening, and required employment documentation, were completed for existing employees and newly hired staff.
- On June 25, 2026, the attending physician group was contacted to verify all resident physician orders. The discrepancy identified between physician orders and medication administration was corrected immediately. The licensed Administrator subsequently completed a comprehensive audit comparing physician orders to the Medication Administration Records (MARs) to verify all medications accurately reflected current physician orders.

How Other Residents Were Protected

- The Administrator completed a 100% audit of resident records to verify physician orders, medication administration records, therapeutic diet orders, resident care plans, referrals, and follow-up appointments. Any discrepancies identified during the audit were corrected immediately.
- A 100% audit of personnel files was completed to verify compliance with state hiring requirements, Medication Aide qualifications, CPR certification, criminal background checks, controlled substance screening, orientation, and competency validation. Deficiencies identified during the audit were corrected immediately.

Systemic Changes Implemented

- A licensed North Carolina Adult Care Home Administrator is responsible for oversight of daily operations, regulatory compliance, resident care, staffing, dietary services, and quality assurance.
- Medication Aide competency validations will be completed by the Pharmacy Registered Nurse prior to independent medication administration.
- Personnel files will be reviewed using a standardized pre-employment checklist prior to an employee working independently.
- The facility has implemented the Grove Menu Program, utilizing registered dietitian-developed regular and therapeutic menus, standardized recipes, tray cards, production records, and Master Diet Rosters to ensure physician-prescribed diets are accurately prepared and served.
- All physician diet orders are verified with the provider as needed and immediately updated on the Master Diet Roster, tray cards, resident care plans, and kitchen reference materials.
- The Clinical Coordinator will utilize a standardized Physician Order Communication Process to ensure every new physician order is reviewed and accurately transcribed to the Medication Administration Record (MAR), Treatment Administration Record (TAR), resident care plan, tray card (when applicable), and Master Diet Roster prior to implementation.
- Dietary employees complete therapeutic diet education during orientation utilizing DHSR training materials and receive ongoing continuing education and competency validation to maintain compliance with therapeutic diet requirements.
- The Clinical Coordinator maintains the Pre-Admission Appointment Tracking Log to ensure physician appointments scheduled prior to admission are completed following admission.
- CPR certification is monitored through an ongoing tracking system to ensure certifications remain current and CPR-certified staff are present on every shift.
- The Administrator routinely audits physician orders against the MAR to ensure medications are administered exactly as prescribed.
- Monthly interdisciplinary Quality Assurance meetings are conducted with the Administrator, Clinical Coordinator, Dietary Manager (or dietary designee), Pharmacy Consultant, and other appropriate members of the management team to review medication administration, therapeutic diet compliance, physician orders, resident appointments, choking or aspiration incidents, regulatory compliance, and any identified trends requiring corrective action.

Monitoring

- Administrator or designee will monitor compliance as follows:
- Daily for 30 days: Review physician orders and Medication Administration Records (MARs) for accuracy; verify implementation of all new physician orders; verify implementation of all new diet orders; review staffing schedules to ensure CPR-certified staff coverage; and review all new admissions for scheduled physician follow-up appointments.
- Weekly for three months: Audit personnel files for compliance with hiring requirements; audit Medication Aide competency documentation; audit therapeutic diet compliance utilizing the Grove Master Diet Roster; review appointment tracking documentation; observe medication administration; and observe meal preparation and meal service for residents receiving therapeutic diets.
- Monthly for three months: The Administrator and Regional Director will review Quality Assurance audits, including medication administration, dietary compliance, physician order implementation, appointment follow-up, personnel file compliance, CPR compliance, Medication Aide competency, and resident outcomes.

Results of these audits will be discussed during the interdisciplinary Quality Assurance meeting, and any deficiencies identified will be corrected immediately through additional education, competency validation, process improvement, or disciplinary action as appropriate.

Completion Date: 7/24/26

Tag D248

10A NCAC 13F .0704(b) – Resident Contract, Information on Facility, and Resident Register

Corrective Action Taken

Resident Register documentation was reviewed for all current residents. Missing or incomplete required entries, signatures, and dates were corrected with the resident and/or responsible representative as appropriate.

How Other Residents Were Protected

A 100% audit of current resident records was completed to verify that a Resident Register was completed, signed, dated, maintained, and updated as required.

Systemic Changes Implemented

Completion and verification of the Resident Register has been incorporated into the admission checklist. The Administrator or designee will verify completion before the admission record is considered complete.

Monitoring

The Administrator or designee will audit all new admissions for Resident Register completion and will review existing Resident Registers monthly for three months.

Completion Date: _____July 31,2026_____

Tag D273

10A NCAC 13F .0902(b) – Health Care / Referral and Follow-Up

Corrective Action Taken

Outstanding physician, specialist, diagnostic, and therapy referrals identified during the survey were reviewed. Required follow-up appointments/referrals were scheduled or otherwise addressed with the appropriate provider, and documentation was placed in the resident record.

How Other Residents Were Protected

A 100% audit of current resident records was completed to identify outstanding physician orders, referrals, specialist appointments, diagnostic services, and follow-up needs. Any outstanding items identified were addressed.

Systemic Changes Implemented

The facility implemented a standardized appointment/referral tracking process. A Pre-Admission Appointment Tracking Addendum is used for appointments known before admission, and the Clinical Coordinator or designee maintains an ongoing tracking log for referrals and follow-up appointments after admission.

Monitoring

The Administrator or designee will review new orders/referrals and the appointment tracking log daily for 30 days, weekly for three months, and as part of monthly Quality Assurance review.

Completion Date: July 27, 2026

Tag D296

10A NCAC 13F .0904(c)(7) – Nutrition and Food Service / Matching Therapeutic Diet Menu

Corrective Action Taken

The facility reviewed all physician-ordered therapeutic diets and implemented the Grove Menu Program, which provides registered-dietitian-developed regular and therapeutic menus, standardized recipes, tray cards, production records, and related dietary compliance tools. Matching therapeutic diet guidance is maintained for residents with physician-ordered therapeutic diets.

How Other Residents Were Protected

All current diet orders were reviewed and compared with available menus and dietary guidance to ensure appropriate therapeutic menu instructions were available to dietary staff.

Systemic Changes Implemented

All new or changed therapeutic diet orders will be communicated to dietary staff and incorporated into the Master Diet Roster, tray cards, resident care documentation, and applicable therapeutic menu guidance before implementation.

Monitoring

The Administrator or designee will audit therapeutic diet orders against the Grove menu system and Master Diet Roster weekly for three months. Meal preparation/service for therapeutic diets will also be observed weekly.

Completion Date: _____July 27, 2026_____

Tag D309

10A NCAC 13F .0904(e)(3) – Nutrition and Food Service / Current Therapeutic Diet Listing

Corrective Action Taken

All resident physician diet orders were reviewed and a current Master Diet Roster was established identifying residents receiving therapeutic diets. The roster is maintained in the kitchen for dietary staff reference.

How Other Residents Were Protected

A 100% review of current residents' physician diet orders was completed and compared with the Master Diet Roster, tray cards, and dietary information used by food-service staff.

Systemic Changes Implemented

The Clinical Coordinator or designee will communicate every new or changed physician diet order to dietary staff and ensure the Master Diet Roster and related dietary documents are updated promptly.

Monitoring

The Administrator or designee will compare current physician diet orders with the Master Diet Roster weekly for three months and review results during monthly Quality Assurance meetings.

Completion Date: July 27, 2026

Tag D310

10A NCAC 13F .0904(e)(4) - Nutrition and Food Service - Therapeutic Diets - TYPE A1 VIOLATION

Corrective Action Taken

- Immediately upon identification of the deficient practice, the facility implemented the approved Plan of Protection to ensure resident safety. Resident #4's physician orders were immediately reviewed and verified to ensure the resident received the prescribed pureed diet with nectar-thickened liquids. The resident's care plan, diet roster, and tray card were updated to accurately reflect the physician's orders and swallowing precautions.
- A licensed North Carolina Adult Care Home Administrator was hired effective July 13, 2026, and assumed responsibility for oversight of all facility operations, including dietary services, regulatory compliance, quality assurance, and implementation of physician-ordered therapeutic diets.
- A 100% audit of all resident physician diet orders was completed to verify that prescribed diets, food textures, liquid consistencies, nutritional supplements, and dining assistance requirements were accurately reflected on physician orders, care plans, tray cards, and the kitchen diet roster. Any discrepancies identified during the audit were corrected immediately.
- The facility enrolled in the Grove Menu Program, a dietary management system developed by registered dietitians that provides therapeutic menu planning, standardized recipes, master diet rosters, tray cards, production records, and other dietary compliance tools. The Grove Menu Program has been implemented to ensure physician-ordered therapeutic diets are accurately communicated, prepared, and served according to physician orders and North Carolina Adult Care Home regulations.
- The facility purchased and maintains the equipment and supplies necessary to safely prepare therapeutic diets, including an immersion blender and thickening products for nectar-thickened liquids and other prescribed liquid consistencies.
- All dietary staff, medication aides, personal care aides, and management staff completed education on therapeutic diets utilizing training materials provided by the North Carolina Division of Health Service Regulation (DHSR) and Relias. Training included physician-ordered therapeutic diets, dysphagia, aspiration precautions, puree consistency standards, thickened liquid preparation, proper use of the Grove Menu Program, and the importance of following physician orders without deviation. Staff competency was validated following completion of training.

How Other Residents Were Protected

- A comprehensive review of all residents receiving therapeutic diets was completed to verify:
- Physician diet orders were current and accurately implemented.
- Tray cards and the Master Diet Roster matched physician orders.
- Therapeutic diets, including modified textures and thickened liquids, were prepared and served as ordered.
- Nutritional supplements and thickening agents were available.
- Resident care plans accurately reflected swallowing precautions and dining assistance needs.
- The Administrator observed meal preparation and meal service for residents receiving therapeutic diets to verify compliance with physician orders. Any discrepancies identified were corrected immediately.

Systemic Changes Implemented to Prevent Recurrence

- A licensed North Carolina Adult Care Home Administrator is responsible for oversight of dietary services, physician order implementation, quality assurance, and regulatory compliance.
- The facility utilizes the Grove Menu Program, which provides registered dietitian-developed therapeutic menus, standardized recipes, master diet rosters, tray cards, production records, and dietary compliance resources to ensure meals are prepared and served according to physician orders.
- A current Master Diet Roster is maintained in the kitchen and updated immediately whenever a physician changes a resident's diet order.

- Physician diet orders are communicated in writing through updated tray cards, the Master Diet Roster, resident care plans, and kitchen dietary reference materials prior to the next scheduled meal.
- Therapeutic diet menus and standardized recipes remain readily available in the kitchen for staff reference at all times.
- The facility maintains the equipment and supplies necessary to prepare therapeutic diets, including an immersion blender and thickening products.
- New dietary employees receive orientation on therapeutic diet preparation prior to independently preparing resident meals.
- All dietary staff receive ongoing education and competency validation regarding physician-ordered therapeutic diets, dysphagia management, aspiration precautions, puree consistency standards, thickened liquids, and safe food preparation techniques.
- Any resident experiencing a choking episode, aspiration event, or significant change in swallowing ability will receive an immediate interdisciplinary review. The physician, responsible party, consulting Registered Nurse, and Administrator will be notified in accordance with facility policy, and the resident's care plan and dietary orders will be reviewed and updated as appropriate.
- The Administrator reviews all physician diet orders daily to ensure consistency between physician orders, resident care plans, tray cards, the Master Diet Roster, and meals served.

Quality Assurance and Monitoring

- The Administrator or designee will monitor compliance as follows:
- Daily for 30 days: Review all new physician diet orders; verify tray cards, the Master Diet Roster, and resident care plans accurately reflect physician orders; observe meal preparation and meal service for residents receiving therapeutic diets; and verify therapeutic menus, recipes, thickening products, and equipment remain available.
- Weekly for three months: Audit 100% of residents receiving therapeutic diets to ensure meals served match physician orders; observe dietary staff preparing therapeutic diets utilizing Grove recipes and menus; verify proper preparation of modified texture diets and thickened liquids; review documentation of choking incidents, aspiration events, physician notifications, and responsible party notifications; and validate ongoing staff competency related to therapeutic diet preparation.
- Monthly for three months: The Administrator and Regional Director will review Quality Assurance audits to evaluate compliance with therapeutic diet requirements, physician orders, staff training, resident outcomes, and dietary operations. Any identified deficiencies will be corrected immediately through additional education, competency validation, process improvement, or disciplinary action when indicated.

Completion Date: 7/24/26

Tag D316

10A NCAC 13F .0905(c) – Activities Program

Corrective Action Taken

A current monthly activity calendar was developed and posted in a location accessible to residents. Responsibility for development, review, and posting of the calendar was reassigned so that the activity program continues during leadership or staffing changes.

How Other Residents Were Protected

Resident interests and capabilities were reviewed and incorporated into planned individual and group activities. Residents were informed of the current activity schedule and encouraged to participate.

Systemic Changes Implemented

The Administrator or designee will ensure a monthly activity calendar is completed and posted no later than the first day of each month and updated when changes occur. The activity program will include resident input, appropriate supplies/assistance, and use of community resources when available.

Monitoring

The Administrator or designee will verify calendar posting on the first day of each month and review activity documentation weekly for three months. Activity-program effectiveness and resident input will be documented at least every six months.

Completion Date: _____July 22, 2026_____

Tag D317

10A NCAC 13F .0905(d) – Activities Program / 14 Hours of Group Activities

Corrective Action Taken

The activity schedule was revised to provide at least 14 hours each week of varied planned group activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills.

How Other Residents Were Protected

All residents were given access to the revised activity schedule and encouraged to participate based on their interests and capabilities.

Systemic Changes Implemented

The monthly calendar and weekly activity plan will be reviewed before posting to verify that at least 14 hours of qualifying planned group activities are scheduled each week. Staff responsibilities for conducting and documenting activities have been assigned.

Monitoring

The Administrator or designee will audit the activity calendar and activity participation/documentation weekly for three months to verify that at least 14 hours of planned group activities are offered each week.

Completion Date: _____July 22, 2026_____

Tag D319

10A NCAC 13F .0905(f) – Activities Program / Resident Outings

Corrective Action Taken

The facility established a process to ensure residents are offered an outing at least every other month. Transportation options and staffing coverage are reviewed in advance so an inoperable facility vehicle or staffing issue does not eliminate the required opportunity.

How Other Residents Were Protected

Residents were asked about outing interests and preferences, and planned outings were incorporated into the activity program.

Systemic Changes Implemented

The activity calendar will identify planned resident outings, and the Administrator or designee will verify that an outing opportunity is offered at least every other month. Alternative transportation arrangements will be made when the facility vehicle is unavailable.

Monitoring

The Administrator or designee will review the activity calendar monthly for three months and maintain documentation of outings offered, resident participation, and any alternative arrangements.

Completion Date: _____July 22, 2026_____

Tag D358

10A NCAC 13F .1004(a) – Medication Administration – TYPE B VIOLATION

Corrective Action Taken

The medication issues identified for the sampled residents were reviewed with the pharmacy and prescribing providers. Medication availability, refill status, insurance/prior-authorization issues, and current physician orders were reconciled. The facility established follow-up procedures requiring staff to promptly escalate unavailable medications, rejected prescriptions, prior-authorization issues, and missed doses to the pharmacy, prescribing provider, and Administrator/Clinical Coordinator as appropriate.

How Other Residents Were Protected

The Administrator or designee completed a 100% audit of resident physician orders, medication administration records, and medications on hand to identify unavailable medications, missed doses, refill problems, prior-authorization issues, or discrepancies. Identified discrepancies were addressed with the pharmacy and/or prescribing provider.

Systemic Changes Implemented

The facility implemented a standardized medication availability and physician-order communication process. Medication cart audits include verification that medications are on hand in sufficient quantity. New physician orders are reviewed and accurately transcribed to the MAR/TAR and other applicable resident-care records before implementation. Staff are required to report unavailable medications and missed doses promptly rather than waiting for routine cycle fill.

Monitoring

Consistent with the facility-wide corrective systems already established under D177, the Administrator or designee will review physician orders and MARs daily for 30 days, verify medication availability and follow-up on missed doses, and observe medication administration weekly for three months. Medication-administration audit results will be reviewed monthly with the Regional Operations Director through the Quality Assurance process for three months. Any discrepancy will be corrected immediately.

Completion Date: July 22, 2026
NOTE: DHSR states the correction date for this Type B violation shall not exceed August 9, 2026.

LSB reviewed and acknowledged 08/10/26
8/7/26