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
	HAL056005	A. BUILDING: _____ B. WING _____	R 07/16/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services conducted an annual and follow-up survey on July 14, 2026 through July 16, 2026.	D 000	While a review of staffing records confirms that the total staffing hours provided met or exceeded the minimum state regulatory requirements, we recognize that the specific care and supervision needs of one resident were not adequately addressed at all times during the period cited. We remain committed to ensuring that every resident receives the appropriate level of care regardless of minimum hour benchmarks. Corrective Action To enhance patient care and ensure comprehensive operational oversight, the facility is currently actively hiring to increase its staffing levels, specifically targeting the consistent placement of at least three med staff members on every night shift. This measure aims to bolster coverage and response time during critical hours. Additionally, as part of our commitment to safety and high-quality support, all residents who require extra care and a higher degree of continuous supervision have been moved to the main floor. This strategic relocation ensures that their specialized needs are met promptly, consistently, and with minimal delay by the care team.	8/10/26
D 194	10A NCAC 13F .0608 (a)(b) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents (a) Each facility with a census of 21 or more residents shall have staff on duty to meet the needs of the residents. (b) In addition to the requirement in Paragraph (a) of this Rule, each facility with a census of 21 or more residents shall comply with the following staffing requirements: (1) On first shift and second shift, the total aide duty hours shall be at least: (A) 16 hours of aide duty for facilities with a census of 21 to 40 residents. (B) 20 hours of aide duty for facilities with a census of 41 to 50 residents. (C) 24 hours of aide duty for facilities with a census of 51 to 60 residents. (D) 28 hours of aide duty for facilities with a census of 61 to 70 residents. (E) 32 hours of aide duty for facilities with a census of 71 to 80 residents. (F) 36 hours of aide duty for facilities with a census of 81 to 90 residents. (G) 40 hours of aide duty for facilities with a census of 91 to 100 residents. (H) 44 hours of aide duty for facilities with a census of 101 to 110 residents. (I) 48 hours of aide duty for facilities with a census of 111 to 120 residents. (J) 52 hours of aide duty for facilities with a	D 194		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Tiffany — TITLE: Administrator — (X6) DATE: 8-10-26

LSB Reviewed and acknowledged 08/11/26

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 194	Continued From page 1 census of 121 to 130 residents. (K) 56 hours of aide duty for facilities with a census of 131 to 140 residents. (L) 60 hours of aide duty for facilities with a census of 141 to 150 residents. (M) 64 hours of aide duty for facilities with a census of 151 to 160 residents. (N) 68 hours of aide duty for facilities with a census of 161 to 170 residents. (O) 72 hours of aide duty for facilities with a census of 171 to 180 residents. (P) 76 hours of aide duty for facilities with a census of 181 to 190 residents. (Q) 80 hours of aide duty for facilities with a census of 191 to 200 residents. (R) 84 hours of aide duty for facilities with a census of 201 to 210 residents. (S) 88 hours of aide duty for facilities with a census of 211 to 220 residents. (T) 92 hours of aide duty for facilities with a census of 221 to 230 residents. (U) 96 hours of aide duty for facilities with a census of 231 to 240 residents. (2) On third shift, the total aide duty hours shall be at least: (A) 8 hours of aide duty for facilities with a census of 21 to 30 residents. (B) 16 hours of aide duty for facilities with a census of 31 to 60 residents. (C) 24 hours of aide duty for facilities with a census of 61 to 90 residents. (D) 32 hours of aide duty for facilities with a census of 91 to 120 residents. (E) 40 hours of aide duty for facilities with a census of 121 to 150 residents. (F) 48 hours of aide duty for facilities with a census of 151 to 180 residents. (G) 56 hours of aide duty for facilities with a census of 181 to 210 residents.	D 194	Systemic Changes The facility is transitioning from a model based solely on minimum required hours to an acuity-based staffing model. This systemic change ensures that staffing levels and assignments are directly aligned with the clinical and personal care needs of the current resident population. By evaluating the collective acuity of our residents, we will adjust staff presence dynamically to ensure that high-need residents receive the focused care they require, ensuring safety and compliance beyond basic regulatory minimums. Monitoring To ensure ongoing compliance and the effectiveness of the new staffing model, the Administrator or Manager will conduct weekly audits of resident care needs and corresponding staffing assignments. These audits will involve reviewing call light response times, resident status changes, and staff allocation. Results will be reviewed during monthly Quality Assurance (QA) meetings to determine if further adjustments to the staffing model are necessary to maintain the highest standard of care.	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 194	Continued From page 2 (H) 64 hours of aide duty for facilities with a census of 211 to 240 residents. (3) If the Department determines the needs of the residents at a facility are not being met by staffing requirements of Paragraph (b) of this Rule, the Department shall require the facility to employ staff to meet the needs of the residents. This Rule is not met as evidenced by: A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure adequate staffing to meet the needs of residents who resided in the facility that had three residential floors. The findings are: Review of the facility current license by the Division of Health Service Regulation effective 01/01/26 revealed the facility was licensed as an assisted living (AL) with a capacity of 26 beds. Observations during the initial tour on 07/14/26 at 9:00am revealed: -The facility had three floors accessible by an elevator and a staircase. -The main entrance to the facility was on the second floor.	D 194	The RCC, LPN, or RN will conduct daily "Care Rounds" on all shifts for the next 30 days, then weekly thereafter, to verify that residents are receiving care as outlined in their specific care plans. Hourly Rounds: The facility will implement mandatory hourly rounds for all residents identified as requiring additional personal care. Staff will utilize a designated rounding log to document each check, ensuring that resident safety and personal care needs are addressed consistently throughout each shift. Physician Notification: A new protocol has been established to ensure that attending physicians are immediately notified of any significant changes in a resident's condition. This includes, but is not limited to, falls, increased confusion, wandering, or worsening incontinence. All notifications will be documented in the resident's clinical record, including the time of notification and any orders received. Resident Relocation: The facility has implemented a policy to assess resident placement based on clinical need. When clinical assessments indicate that a resident's current room placement no longer meets their care or safety needs—particularly for those on upper levels—the facility will initiate a relocation process to the main level to ensure appropriate supervision and access to care.	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 194	Continued From page 3 -Staff offices were located on the second floor. Review of the facility's current census on 07/14/26 revealed: -There were a total of 21 residents who resided in the facility. -There were 7 residents who resided on each of the floors. Review of the facility census from April 2026 to July 2026 revealed: -The census varied from 20-23 residents. -In April 2026 there were 5 residents who resided on the first floor, 7-10 residents who resided on the second floor and 4 or 5 residents who resided on the third floor. -In May 2026 there were 5 or 6 residents who resided on the first floor, 7 or 8 residents who resided on the second floor and and 5 residents who resided on the third floor. -In June 2026 there were 5 residents who resided on the first floor, 7 or 8 residents who resided on the second floor and 7-9 residents who resided on the third floor. -In July 2026 there were 7 residents who resided on the first floor, 6 or 7 residents who resided on the second floor and and 7 or 8 residents who resided on the third floor. Review of a resident's Incident/Accident Report dated 03/25/26 at 12:02pm revealed: -The incident occurred in the resident's room on the third floor. -It was an unwitnessed fall from a loss of balance, tripped, or slipped and no injuries were noted. -Another resident's family member helped the resident up from the floor and notified staff. -The resident was unsure how she fell. -The resident's primary care provider (PCP) was	D 194		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 194	Continued From page 4 notified. Review of a resident's second Incident/Accident Report dated 05/06/26 at 2:25pm revealed: -The incident occurred in the staff bathroom on the second floor. -The resident had an unwitnessed fall and sustained bruising to her right arm. -The resident's PCP was notified at 2:45pm. -The resident's family member was notified at 2:33pm. -The Manager and the medication aide (MA) assisted the resident up to a standing position without difficulty. Review of a resident's third Incident/Accident report dated 05/22/26 at 10:30pm revealed: -The incident occurred in the resident's room on the third floor. -It was an unwitnessed fall slipping on water in her room and fell onto the floor between the television and chair and the resident's roommate called staff. -The resident was found by staff lying on her back on the wet floor and she complained of pain in her lower back, left hip, and left leg. -A MA called 911 and after emergency medical services (EMS) arrived the resident did not want to be transported to the hospital for an evaluation and was assisted into bed. -Two-hour rounds would be completed for 24 hours after the fall. -The resident's family member was notified on 05/22/26 at 11:00pm. -The resident's PCP was not notified. Review of a resident's fourth Incident/Accident report dated 05/31/26 at 4:19pm revealed: -The incident occurred in the resident's room on the third floor.	D 194		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 194	Continued From page 5 -It was an unwitnessed fall in her room and she was found lying on the floor by a personal care aide (PCA) after the PCA heard the resident yelling for help. -The resident's PCP was notified on 05/31/26 but there was no time documented. -The resident's family member was notified of the fall on 05/31/26 at 6:35pm. Review of a resident's fifth Incident/Accident report dated 06/13/26 at 8:56pm revealed: -The incident occurred in the resident's room on the third floor. -It was an unwitnessed fall and she was found sitting in the floor in front of a chair by a MA with no injuries noted. -The resident refused emergency transport to be evaluated at the local emergency room (ER) on 06/13/26 at 8:56pm. -The resident's PCP was not notified. -The resident's family member was notified on 06/13/26 at 10:00pm. -The Manager was notified of the fall. Review of a resident's sixth Incident/Accident Report dated 06/14/26 at 10:51am revealed: -The incident occurred in the resident's room on the third floor. -It was an unwitnessed fall and she was found lying on the floor with no skin tears or bruising noted. -The resident seemed more confused, reported to staff that she did not know where she was, two staff assisted the resident from the floor into a chair, and the resident was crying reporting her pain was a 10 on a scale of 0-10. -Staff called the resident's family member to "check on her" before the facility sent her to the hospital and after the family member arrived and talked to the resident, the resident was okay and	D 194		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 194	Continued From page 6 not sent to the hospital. -The resident's PCP was notified on 06/14/26 at 9:49pm. -The resident's family member was notified on 06/14/26 at 10:52am. Interview with the Business office Manager (BOM) on 07/15/26 at 3:30pm revealed: -All residents who required wheelchairs for ambulation resided on the second floor. -Residents who were independent and who used a walker or walked without assistance lived on the first and third floors. Interview with a personal care aide (PCA) on 07/15/026 at 11:35am revealed: -She also worked as a medication aide (MA). -Staff were not assigned to specific floors. -Staff constantly reminded one resident who lived on the third floor who had frequent falls to use her call light. -If staff were not on that level, staff could not hear if a resident fell or screamed if they lived on the first or third floor. Interview with a MA on 07/15/26 at 11:10am revealed there was usually only herself and a PCA working during the day shift and there were 3 floors where residents resided, so it was not possible to have staff on each floor. Interview with the Manager on 07/15/26 at 3:40pm revealed: -Staff worked one of two shifts: 7:00am-7:00pm or 7:00pm-7:00am. -One personal care aide (PCA) and one medication aide (MA) worked each shift. -Staff were not assigned to any particular floor. -"In general" there was always staff on the second floor and someone floated between the	D 194		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 194	Continued From page 7 first and third floor. -She thought two staff were able to supervise and provide care to residents living on three floors because they made rounds to check on residents every two hours. -Some residents used the call pendants they wore but others forgot to use them. -The owners of the facility would not want to hire and fire staff based on the changing needs of residents because that was "not profitable". -The facility was very quiet so staff heard every fall that happened. -Independent residents lived on the first and third floors and residents who needed more assistance and "eyes on" lived on the second floor. -When a resident started to decline they were relocated to the second floor. -The family agreed in July 2026 to move the resident when a room became available that had a view of the parking lot. Interview with the Administrator on 07/16/26 at 11:25am revealed: -The facility was staffed according to the state regulations. -She thought two staff providing care to 21 residents who resided on three floors was adequate because rounds were made every two hours and cameras in the facility helped her monitor if staff completed the rounds. Refer to Tag D 270 NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation). The facility failed to ensure adequate staffing to meet the needs of the residents, resulting in a resident who lived on the third floor sustaining six falls and failed to move her to the second floor where she could be monitored more closely. When she had the last fall she sustained a	D 194		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 194	Continued From page 8 fractured pelvis. This failure resulted in substantial risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on July 15, 2026 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 14, 2026.	D 194	Corrective Action Taken The facility has implemented a new tracking sheet for Resident Care Plans, developed by the LPN and RN to ensure all care requirements are captured accurately and timely. Moving forward, the facility will strictly use "Form 3050R" for all resident care plans. Measures Put in Place/Systemic Changes The Manager will conduct regular chart audits to verify that all Resident Care Plans are accurate and completed in accordance with regulatory timelines. All staff have been re-trained on the facility's documentation policy for care plans, emphasizing the requirement for timely updates whenever a resident's status changes. Staff are required to update care plans within 72 hours of a change in resident status or following a fall incident to ensure the plan accurately reflects the resident's current clinical needs.	8/3/2026
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter;	D 259		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 259	Continued From page 9 (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure the physician signed and dated the care plan within 15 days for 2 of 3 sampled residents (Resident (#2, and #3). The findings are: 1. Review of Resident #2's current FL2 dated 11/10/25 revealed diagnoses included hypertension, anemia, spinal stenosis and glaucoma.	D 259	Monitoring Procedures The Administrator will review the results of these chart audits during monthly Quality Assurance (QA) meetings to ensure sustained compliance. The facility has implemented the "Single Point of Contact (SPOC)" oversight model, assigning specific staff responsibility for tracking paperwork programs. The "48-Hour Follow-Up Rule" has been established; for any paperwork sent to physician offices not returned within 48-72 hours, staff must perform and document a follow-up call.	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 259	Continued From page 10 Interview with Resident #2 on 07/14/26 at 9:40am revealed staff helped him with dressing, bathing and transfers into and out of his wheelchair. Review of Resident #2's Resident Register revealed an admission date of 08/20/25. Review of Resident #2's care plan dated 08/21/25 revealed: -Resident #2 required supervision with ambulation, toileting, bathing, grooming, dressing and transfers. -Resident #2 was independent with eating. -Resident #2's care plan was not signed by the primary care provider (PCP). Review of Resident #2's unsigned care plan dated 01/05/26 revealed: -Resident #2 was independent with transfers, dressing, grooming, toileting, bathing and eating. -Resident #2 ambulated with a wheelchair. -Resident #2's care plan was not signed by the PCP. Refer to the interview with the RCC on 7/14/26 at 4:03pm. Refer to the interview with the Manager on 07/16/25 at 11:03am. Refer to the interview with the Administrator on 07/14/26 at 2:45pm and 07/16/26 at 10:41am. 2. Review of Resident #3's current FL2 dated 04/07/26 revealed diagnoses included hypertension, memory impairment, osteopenia (low bone density), depression and anxiety. Review of Resident #3 Resident Register dated 11/23/22 revealed her date of admission was	D 259		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 259	Continued From page 11 12/09/22. Review of Resident #3's care plan dated 06/29/2026 revealed: -She required extensive assistance with mobility, and was unable to ambulate due to a pelvic fracture. -She required extensive assistance with transferring due to her pelvic fracture. -She required assistance with dressing and morning care because of her pelvic fracture. -She required extensive assistance with personal hygiene/grooming due to her pelvic fracture. -She was unable to use the toilet at this time. -She required assistance with bathing by having a bed bath. -She needed extensive assistance with nighttime preparation due to her pelvic fracture. -Resident #3's care plan was not signed by the PCP. Refer to the interview with the RCC on 7/14/26 at 4:03pm. Refer to the interview with the Manager on 07/16/25 at 11:03am. Refer to the interview with the Administrator on 07/14/26 at 2:45pm and 07/16/26 at 10:41am. Interview with the RCC on 07/14/26 at 4:03pm revealed: -The LPN completed care plans and sent them to the PCP's office to be signed. -All care plans were supposed to be signed by the PCP. -The care plans that were completed the previous week were not taken over to the PCP's office until earlier today (07/14/26). -The Registered Nurse (RN) was responsible for	D 259		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 259	Continued From page 12 getting the PCP signatures on the care plans. Interview with the Manager on 07/16/25 at 11:03am revealed: -She was responsible for taking care plans to the PCP's office so they could be signed. -Since she was responsible for ensuring care plans were signed she should have "bugged them" until it they were signed and returned. Interview with the Administrator on 07/14/26 at 2:45pm and 07/16/26 at 10:41am revealed: -The RN was responsible for completing care plans and making sure the physician's signed each care plan. -She did not realize the RN was not ensuring the care plans were signed by a physician. -Sometimes they could not get the physician to sign the care plans right away. -The RCC was responsible for keeping up with resident forms and what needed to be signed. -No one had been doing chart audits so they did not know what was incomplete in the charts. -She was ultimately responsible for checking records and making sure care plans were signed by the physician.	D 259		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents (Resident #3) with multiple falls and injuries. The findings are: Review of Resident #3's current FL2 dated 04/07/26 revealed: -Diagnoses included hypertension, third-degree atrioventricular block, depression, anxiety, memory impairment, and osteopenia (low bone density).. -She was ambulatory with a walker, intermittently disoriented, continent of bowel and bladder. -She required personal care assistance with bathing. -Recommended level of care was documented as assisted living facility. -Her functional limitation was documented as sight. Review of Resident #3's Resident Register dated 11/23/22 revealed: -Date of admission was 12/09/22. -There was documentation Resident #3 required assistance with bathing. -Special aids were documented as walker, eyeglasses, and dentures. -Memory was documented as forgetful and needed reminders. Review of Resident #3's Care Plan dated 1/29/26	D 270	Corrective Action Taken The facility has initiated hourly rounds for all residents identified as requiring additional personal care and supervision. A new notification protocol has been established to ensure physicians are immediately alerted to any changes in resident condition, including but not limited to falls, confusion, wandering, and incontinence. Staff have been educated on the "Trigger Criteria" for immediate physician notification and incident reporting. The facility has implemented a mandatory daily debriefing meeting for all shifts to review any identified care gaps or concerns from the previous 24 hours, ensuring immediate accountability. Measures Put in Place/Systemic Changes Residents requiring additional care will have their care plans reviewed monthly to assess the ongoing appropriateness of their care and living arrangements.	8/10/26

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 14 revealed: -She was independent with ambulation and used a walker. -She was independent with transfers, bathing, and bed-making. -She was able to communicate and demonstrate understanding in words and actions. -She used good judgement, her memory was good, and she made sound decisions. Review of Resident #3's Care Plan dated 06/29/26 revealed: -She required extensive assistance with mobility, transfers, dressing, and personal hygiene due to a pelvic fracture. -She was unable to ambulate to the bathroom at this time. -She required assistance with bed baths. Review of Resident #3's unsigned Care Plan dated 7/10/26 revealed: -Ambulation was documented as ambulatory with a walker and she required two-person assistance with a few steps related to a pelvic fracture. -She had limited range of motion and strength in upper extremities. -She was sometimes disoriented with a significant loss of memory and needed to be directed. -She was incontinent of bowel and bladder and required extensive assistance with toileting. -She was totally dependent with ambulation, transferring, bathing, dressing, grooming and personal hygiene. -There was documentation Resident #3 had a fractured pelvis and required extensive help handwritten in the box marked other. Review of Resident #3's fall risk assessment form dated 07/10/26 revealed: -She had a total score of 20 (a total score of 10 or	D 270	If deemed necessary following a monthly review, residents requiring higher levels of care or monitoring will be transitioned to the main level of the facility. The monthly review process will utilize a standardized "Level of Care Assessment" form to objectively determine if a resident requires the increased supervision found on the main level. For fall-related documentation, staff must record the specific interventions attempted (such as chair alarms, bed alarms, or increased rounding) and the clinical results of those interventions, adhering to the facility's post-fall documentation protocols. We have implemented a "Zero-Tolerance Policy" for missed documentation or rounds, coupled with an automated alert system that flags any delays in service logs for immediate administrative review.	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 15 above represented a high risk for falls). -There were no fall interventions identified to decrease the risk of future falls. Review of Resident #3's Incident/Accident Report dated 03/25/26 at 12:02pm revealed: -The incident occurred in Resident #3's room on the third floor. -Resident #3 had an unwitnessed fall from a loss of balance, tripped, or slipped and no injuries were noted. -Another resident's family member helped Resident #3 up from the floor and notified staff. -Resident #3 was unsure how she fell. -Resident #3's primary care provider (PCP) was notified. Review of Incident/Accident Report dated 05/06/26 at 2:25pm revealed: -The incident occurred in the staff bathroom on the second floor. -Resident #3 had an unwitnessed fall and sustained bruising to her right arm. -Resident #3's PCP was notified at 2:45pm. -Resident #3's family member was notified at 2:33pm. -The Manager and the medication aide (MA) assisted Resident #3 up to a standing position without difficulty. Review of Resident #3's Incident/Accident report dated 05/22/26 at 10:30pm revealed: -The incident occurred in Resident #3's room on the third floor. -Resident #3 had an unwitnessed fall slipping on water in her room and fell onto the floor between the television and chair and Resident #3's roommate called staff. -Resident #3 was found by staff lying on her back on the wet floor and she complained of pain in	D 270	Monitoring Procedures The LPN and RN will conduct weekly audits of rounds logs and physician notification records to ensure consistent implementation. The Administrator will review these audit findings during the monthly Quality Assurance (QA) meeting to ensure sustained compliance and identify any necessary adjustments. Any trends or missed documentation identified will be documented in a monthly compliance report to inform staff re-training and necessary process improvements. The Administrator will conduct daily unannounced floor observations to personally verify that care standards are being met, with findings and corrective actions documented in a high-priority "Compliance Log" that is reviewed daily to ensure rapid response to any identified deficiencies.	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 16 her lower back, left hip, and left leg. -A MA called 911 and after emergency medical services (EMS) arrived Resident #3 did not want to be transported to the hospital for an evaluation and was assisted into bed. -Two-hour rounds would be completed for 24 hours after the fall. -Resident #3's family member was notified on 05/22/26 at 11:00pm. -Resident #3's PCP was not notified. Review of Resident #3's Incident/Accident report dated 05/31/26 at 4:19pm revealed: -The incident occurred in Resident #3's room on the third floor. -Resident #3 had an unwitnessed fall in her room and was found lying on the floor by a personal care aide (PCA) after the PCA heard Resident #3 yelling for help. -Resident #3's PCP was notified on 05/31/26 but there was no time documented. -Resident #3's family member was notified of the fall on 05/31/26 at 6:35pm. Review of Resident #3's Incident/Accident report dated 06/13/26 at 8:56pm revealed: -The incident occurred in Resident #3's room on the third floor. -Resident #3 had an unwitnessed fall and was found sitting in the floor in front of a chair by a MA with no injuries noted. -Resident #3 refused emergency transport to be evaluated at the local emergency room (ER) on 06/13/26 at 8:56pm. -Resident #3's PCP was not notified. -A physician communication noted that Resident #3 called staff on 06/14/26 at 4:00am and reported "she was hurting all over now". -Resident #3's family member was notified on 06/13/26 at 10:00pm.	D 270		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 17 -The Manager was notified of the fall. Review of Review #3's Incident/Accident Report dated 06/14/26 at 10:51am revealed: -The incident occurred in Resident #3's room on the third floor. -Resident #3 had an unwitnessed fall and was found lying on the floor with no skin tears or bruising noted. -Resident #3 seemed more confused, reported to staff that she did not know where she was, two staff assisted Resident #3 from the floor into a chair, and Resident #3 was crying reporting her pain was a 10 on a scale of 0-10. -Staff called Resident #3's family member to "check on her" before the facility sent Resident #3 to the hospital and after the family member arrived and talked to Resident #3, Resident #3 was okay and not sent to the hospital. -Resident #3's PCP was notified on 06/14/26 at 9:49pm. -Resident #3's family member was notified on 06/14/26 at 10:52am. Review of Resident #3's chart notes dated 05/01/26 through 07/16/26 revealed: -There was no documentation of fall prevention interventions or increased supervision implemented after Resident #3 fell on 03/25/26, 05/06/26, 05/22/26, 05/31/26, 06/13/26, and 06/14/26. -On 05/06/26 at 2:34pm, the Manager heard a loud noise and proceeded to check the lobby staff bathroom on the second floor where she found Resident #3 sitting on the floor and slight bruising was noted on Resident #3's right arm. -On 05/22/26 at 10:30pm, Resident #3 had an unwitnessed fall in her room when she slipped on water and complained of pain in her lower back, left hip and left leg. EMS was contacted for	D 270		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 18 evaluation and Resident #3 refused to go to the ER for evaluation and was assisted back to her bedroom. -On 05/31/26 at 6:19pm, Resident #3 fell in the floor and complained of pain in both her hips and right shoulder. Her vital signs were taken and the POA was contacted. -On 06/13/26 at 8:56pm, Resident #3 had an unwitnessed fall in her room and was found by the MA with no visible marks or bruises noted and the Manager and Resident #3's family member were notified. -On 06/14/26 at 10:50am, Resident #3 was found lying on the floor of her room, complained of terrible pain and rated the pain as a 10. The PCA took Resident #3's vital signs and the MA contacted Resident #3's family member. Review of Resident #3's hospital ER discharge instructions dated 06/27/26 revealed: -Reason for visit was Resident #3 complained of pain and leg swelling. -Resident #3 had a hip/pelvic x-ray and was diagnosed with a pelvic fracture. Review of the hospital discharge instructions dated 07/07/26 revealed: -Resident #3 was evaluated and diagnostic results included a non-displaced U-shaped sacral fracture with transverse extension at the junction of S2 and 3 but no kyphotic deformity (type of fracture involving the lower spine and pelvis). -A recommendation to a skilled nursing facility was made for rehabilitation. Review of Resident #3's record revealed: -There was no documentation of increased supervision for Resident #3 after the first fall on 03/25/26. -There were no orders for fall prevention	D 270		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 19 interventions ordered for Resident #3 after the first fall on 03/25/26. Interview with Resident #3 on 07/15/26 at 3:32pm revealed: -She had experienced several falls and complained to staff about the pain. -She knew her last fall was "bad", but she just made herself keep moving even though she was in pain. -She was still in terrible pain. -Her pain was so bad she thought she was going to die when she got her family member to take her to the hospital to be evaluated. Interview with Resident #3's family member on 07/15/26 at 3:40pm revealed: -He had noticed that she was having a harder time getting out of her chair and that is when he thought something was wrong. -Resident #3 woke up one morning in pain about a week after her last fall and another family member was notified. -The other family member contacted 911 for Resident #3 to be sent to the ER to be evaluated. Interview with a MA on 07/15/26 at 9:30am and 11:10am revealed: -Resident #3's room was moved from the third floor down to the second floor while she was in the hospital so staff could "keep eyes on her better". -Staff were supposed to document 2-hour rounds for 24 hours for Resident #3 after each fall. -Staff were supposed to complete 2-hour rounds for all residents, but they did not document the rounds unless a resident had a fall and then staff documented the 2-hour rounds for 24 hours. -She was not instructed by management to implement any fall prevention interventions or	D 270		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 20 increase supervision for Resident #3 after any of Resident #3's falls. -A chair or bed alarm would not have worked for Resident #3 because staff would not have been able to hear it since Resident #3's room was previously located on the 3rd floor. -There is usually only herself and a PCA working during a shift and there were 3 floors where residents reside, so it was not possible to have staff on each floor. Interview with the Manager on 07/15/26 at 11:16am and 11:57am revealed: -There was no fall interventions put into place after each of Resident #3's falls. -They did not have a supervision or fall policy. -Staff informed residents to use their call lights to get assistance and try to prevent falls. -Resident #3's family talked with her about falls and moving her to the second floor where more staff were located and she agreed. -Resident #3's room was moved to the second floor after they found out Resident #3 had sustained a pelvic fracture after a fall. -There was one MA and one PCA scheduled to work each shift and the facility had residents that resided on three levels. -The residents had call bells, but they could only be heard on the second floor. -Staff may not hear a call bell if they are not on the second floor when a resident called. -She did not instruct staff to increase supervision or implement any fall interventions for Resident #3 after each fall. -Staff rounded on residents every 2 hours. Interview with a PCA on 07/15/026 at 11:35am revealed: -Staff constantly reminded Resident #3 to use her call light.	D 270		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 21 -Resident #3's room used to be upstairs, and staff could not hear her if she did fall or scream if staff were not on that floor level. -Staff completed 2-hour rounds on all residents, but they did not document the rounds unless a resident fell. -Staff completed 2-hour rounds for 24 hours for Resident #3 and signed a rounding sheet after Resident #3 had a fall. -She was not told by management to increase the frequency of supervision for Resident #3 after any of Resident #3's falls. -Resident #3 fell on 06/14/26 and started complaining to staff about her pain about 7 days later. -On 06/27/26, Resident #3 was taken to the emergency room for treatment, evaluation and diagnosed with a pelvic fracture. -She was not told by management to do anything additional after Resident #3's falls. Interview with Resident #3's family member on 07/16/26 at 12:27pm revealed: -Resident #3 had dementia. -Resident #3 had a call button but could not remember to use it to call staff for assistance. -Resident #3 experienced a few falls over the past few months. -Resident #3's last fall on 06/14/26 was when she sustained a pelvic fracture. -She was notified of several falls, but the last fall was significant. -She took Resident #3 to the hospital on 06/27/26 for pain and the hospital diagnosed Resident #3 with a pelvic fracture and she was discharged back to the facility that night. -On 06/29/26, Resident #3 was taken back to the hospital for pain and stayed in the hospital for 7 days before being sent back to the facility. -She talked to staff about having Resident #3	D 270		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 22 moved down to the second floor of the facility so that she could be monitored more often. -She started to worry about Resident #3 being on the third floor and staff were not always on that floor, so the facility moved Resident #3's room to the second floor while she was hospitalized. -Staff did not tell her they increased supervision for Resident #3 after a fall. -Staff told her they checked on Resident #3 but did not say how often. Telephone interview with Resident #3's PCP on 07/15/26 at 4:52pm revealed: -He thought he was notified after each of Resident #3's falls. -She had a pelvic fracture, stayed in the hospital for a week, and had just returned to the facility. -The facility did not have enough staff to be able to watch Resident #3 for 24 hours per day. -He did not recall if staff had asked him about fall prevention interventions to decrease Resident #3 risk of falls. -Resident #3 had a mild cognitive impairment, and she was not as sharp as she used to be. -He believed the facility needed more staff for supervision of residents and if a resident had a change in condition, they should be evaluated by the ER provider. -Resident #3's fall causing a pelvic fracture placed Resident #3 at risk of developing blood clots, decreased mobility, pain, and during the acute phase bleeding into Resident #3's thigh. Interview with the Administrator 07/16/26 at 10:42pm revealed: -She was not aware of Resident #3's falls occurring on 03/25/26, 05/06/26, 05/22/26, 05/31/26, 06/13/26, and 06/14/26 because staff did not copy the Incident and Accident Reports and put them in her box.	D 270		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 23 -The MAs were supposed to place the Incident/Accident reports in her box, and she would sign them and give them back to staff to file in the residents' records. -They had moved Resident #3 to the main level after her last fall on 06/14/26. -She did not know what staff should do when a resident had multiple falls. -She had the MA contact the residents' family and the PCP after a fall. -Staff completed rounds every 2 hours and the cameras help to monitor if staff completed the rounds. -The facility's policy for falls included to send the resident to the ER to be evaluated and treated after a fall with head injury or if the resident experienced pain. -She did not know why Resident #3 was not sent out to the ER sooner after she fell. -She did not know what interventions could be implemented to reduce falls. The facility failed to provide supervision for Resident #3 who experienced six falls within 3 months with no fall prevention interventions or increased supervision implemented after each fall resulting in the resident sustaining a pelvic fracture which increased the risk of bleeding, developing blood clots, pain, and having decreased mobility. This failure resulted in serious physical harm and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on July 15, 2026. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 14, 2026.	D 270		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 24	D 280		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 2 of 3 sampled residents (Resident #2 and #3) had a Licensed Health Professional Support (LHPS) review completed quarterly by an appropriate licensed health professional.	D 280	Corrective Action Taken The new RN has implemented a tracking sheet to ensure all Licensed Health Professional Support (LHPS) tasks are up to date and accurately recorded. The tracking sheet includes specific columns for task due dates, completion dates, and verifying signatures to ensure clear accountability. Measures Put in Place/Systemic Changes The RN will maintain this tracking sheet as a primary method for monitoring LHPS compliance and timely completion. The RN will cross-reference the tracking sheet weekly against physician orders to ensure no required nursing tasks are missed. Monitoring Procedures The Manager will review the LHPS tracking sheet monthly to ensure ongoing compliance and accuracy. Any trends or missed documentation identified will be documented in a monthly compliance report to inform staff re-training and necessary process improvements.	8/7/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 25 The findings are: 1. Review of Resident #2's current FL2 dated 11/10/25 revealed: -Diagnoses included hypertension, anemia, spinal stenosis and glaucoma. -He used a walker for ambulation. Review of Resident #1's record revealed: -Resident #2 had an order dated 11/26/25 for compression socks. -The most current LHPS review was dated 01/26/26 and included personal care tasks documented as dressing changes as needed. Refer to interview with the Manager on 07/14/26 at 2:30pm. Refer to interview with the Administrator on 07/16/26 at 10:41am. 2. Review of Resident #3's current FL2 dated 04/07/26 revealed diagnoses included hypertension, memory impairment, depression and anxiety. Review of Resident #3's record revealed: -The most current LHPS review was dated 01/20/26 and personal care tasks documented was dressing changes as needed. -There was a note attached to the LHPS documenting Resident #3 wore compression stockings. Refer to interview with the Manager on 07/14/26 at 2:30pm. Refer to interview with the Administrator on 07/16/26 at 10:41am.	D 280		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 26 Interview with the Manager on 07/14/26 at 2:30pm revealed she could not locate any LHPS that were completed since January 2026. Interview with the Administrator on 07/16/26 at 10:41am revealed: -The RN was responsible for completing the LHPS. -Every time she asked the RN about documents she said she completed them but could not find them. -No one did chart audits so they did not know what was incomplete in the charts. -She was ultimately responsible for checking records and making sure charts were up-to-date including the LHPS.	D 280	Corrective Action Taken A licensed dietitian has been contracted to create menus that include all required diets. Extension sheets for each meal have been developed to ensure all dietary needs and preferences are documented and met.	8/5/2026
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to have matching therapeutic diet menus for 4 of 4 sampled residents (#1, #2, #4, #5) with physician-ordered therapeutic diets for guidance of food service	D 296	Measures Put in Place/Systemic Changes The facility has implemented a new menu system reviewed and approved by a licensed dietitian. Staff have been trained on the use of meal extension sheets to ensure accurate service for every resident according to their specific dietary orders. A new "Communication Log" has been implemented in the kitchen to document any dietary changes received from the dietitian, ensuring they are transcribed onto extension sheets within 24 hours of receipt.	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 27 staff related to a low concentrated sweets diet (#1 & #5) a mechanical soft diet (#2) and a gluten-free diet (#4). The findings are: Observation in the kitchen during initial tour on 07/14/26 at 10:04am revealed: -There was a paper on a kitchen counter that documented resident's who had orders for therapeutic diets. -There were no therapeutic diet menus in the kitchen for guidance of food service staff. Review of the listing of therapeutic diets revealed: -Two residents were documented as receiving a low concentrated sweets diet. -One resident was documented as receiving a mechanical soft diet. -One resident was documented as receiving a gluten-free diet. 1. Review of Resident #1's current FL2 dated 11/07/25 revealed: -Diagnoses included congestive heart failure, myocardial infarction, diabetes mellitus type 2, hypothyroidism, neuropathy, and coronary artery disease. -An order for a low concentrated sweets diet. Refer to interview with the cook on 07/14/26 at 10:04am. Refer to interview with the Business Office Manager (BOM) on 07/14/26 at 10:23am. Refer to telephone interview with the Registered Dietitian on 07/15/26 at 10:03am. Refer to interview with the Administrator on	D 296	Monitoring Procedures The Manager or designee will perform weekly meal service audits to ensure that the meals served align with the dietitian-approved menus and extension sheets. Any discrepancies will be addressed immediately and reviewed during the monthly Quality Assurance (QA) meeting. The Manager will conduct unannounced kitchen inspections monthly to verify that food preparation and service practices adhere to food safety and facility protocols. Findings from meal service audits and kitchen inspections will be compiled into a monthly compliance report, which will be used to identify staff training needs or necessary process adjustments.	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 28 07/16/26 at 10:41am. 2. Review of Resident #5's current FL2 dated 06/01/26 revealed: -Diagnoses included diabetes, elevated lipids, gout, hypertension and congestive heart failure. -An order for a low concentrated sweets diet. Refer to interview with the cook on 07/14/26 at 10:04am. Refer to interview with the Business Office Manager (BOM) on 07/14/26 at 10:23am. Refer to telephone interview with the Registered Dietitian on 07/15/26 at 10:03am. Refer to interview with the Administrator on 07/16/26 at 10:41am. 3. Review of Resident # 4's unsigned, undated FL2 revealed diagnoses included chronic joint pain, hypertension, elevated lipids and colitis (inflammation of the inner lining of the large intestine. Review of Resident #4's record revealed an order dated 05/08/25 for a gluten-free diet. Interview with Resident #4 on 07/15/26 at 8:21am revealed the facility always provided a gluten-free diet. Refer to interview with the cook on 07/14/26 at 10:04am. Refer to interview with the Business Office Manager (BOM) on 07/14/26 at 10:23am. Refer to telephone interview with the Registered	D 296		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 29 Dietitian on 07/15/26 at 10:03am. Refer to interview with the Administrator on 07/16/26 at 10:41am. 4. Review of Resident #2's current FL2 dated 11/10/25 revealed diagnoses included hypertension, anemia, spinal stenosis and glaucoma. Review of Resident #2's record revealed an order dated 08/26/25 for a mechanical soft diet. Refer to interview with the cook on 07/14/26 at 10:04am. Refer to interview with the Business Office Manager (BOM) on 07/14/26 at 10:23am. Refer to telephone interview with the Registered Dietitian on 07/15/26 at 10:03am. Refer to interview with the Administrator on 07/16/26 at 10:41am. _____ Interview with the cook on 07/14/26 at 10:04am revealed: -They used the regular menu to prepare all diets. -She did not have access to therapeutic diet menus. -She knew how to adapt the regular menu to make it work for the therapeutic diet orders. -The daily menu papers that residents used to choose their meals were printed by office staff and brought to the kitchen each week. Interview with the business office manager (BOM) on 07/14/26 at 10:23am revealed: -The facility used a four-week rotation of menus that were prepared by the dietitian that worked for	D 296		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 30 the corporation. -She was responsible for printing out the daily menus and took them to the kitchen at the beginning of each week. -The kitchen used to have menus but they did not use them any more and the cook did not have any therapeutic diet extensions to reference. -The cooks "just knew" how to prepare the foods and were able to adapt the regular menu to fit the therapeutic diets. Telephone interview with a Registered Dietitian on 07/15/26 at 10:03am revealed: -She developed menus, including therapeutic diet menus for the facility about five years ago. -No one from the facility requested updates to the menus until yesterday (07/14/26). -Yesterday the BOM sent her a listing of the therapeutic diet menus they had used previously but they did not match the current resident diet orders. Interview with the Administrator on 07/16/26 at 10:41am revealed: -She did not know the residents current diet orders did not have a matching therapeutic diet menu. -She knew the cooks were not following the old menus they had used in the past. -She ultimately was responsible for ensuring the kitchen had current menus since the food service director was on leave.	D 296		
D 349	10A NCAC 13F .1002 (f) Medication Orders 10A NCAC 13F .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing	D 349		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 349	Continued From page 31 orders and orders for self-administration are reviewed and signed by the resident's physician or prescribing practitioner at least every six months. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure all current orders for medications and treatments were reviewed and signed by the resident's primary care provider (PCP) at least every 6 months for 2 of 3 sampled residents (Resident #1 and #2). The findings are: 1. Review of Resident #1's current FL2 dated 11/07/25 revealed diagnoses included congestive heart failure, myocardial infarction, diabetes mellitus type 2, hypothyroidism, neuropathy, and coronary artery disease. Review of Resident #1's physician's medication orders dated 11/07/25 revealed: -There was an order for amitriptyline (used to treat chronic nerve pain) 25 mg take 1 tablet daily at bedtime. -There was an order for aspirin (used as a blood thinner to prevent heart attacks and strokes in high-risk individuals) 81mg chew 1 tablet daily. -There was an order for bumetanide (used to treat fluid retention and swelling) 1mg take 1 tablet daily. -There was an order for Dexcom (a continuous glucose monitoring device) change every 10 days. -There was an order for Entresto (a combination medication used to treat chronic heart failure and	D 349	Corrective Action Taken The LPN and RN have implemented a new tracking sheet to ensure that all medication orders are current and correct. Measures Put in Place/Systemic Changes The facility has integrated this tracking sheet into daily workflows to maintain accurate medication order documentation. The LPN/RN will perform a monthly "Medication Order Reconciliation" where the facility's master medication list is compared against the pharmacy-provided Medication Administration Records (MARs) to ensure 100% accuracy. Nurses are required to compare physical physician orders against the Medication Administration Record (MAR) to ensure 100% accuracy. If discrepancies are found between orders and the MAR, the orders must be corrected by the physician's office before a nurse provides a signature or files the document.	8/4/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 349	Continued From page 32 blood pressure) 24mg-25mg take ½ tablet twice daily. -There was an order for gabapentin (used to treat nerve pain) 300mg take 1 capsule every morning at 8:00am. -There was an order for gabapentin 300mg take 1 capsule every day at lunch at 12:00pm. -There was an order for gabapentin 600mg take 1 tablet at bedtime. -There was an order for lispro insulin (used to treat elevated blood glucose levels) inject 7 units two hours after the evening meal if the blood glucose level was greater than 180. -There was an order for lispro insulin inject 3 units three times daily as needed for blood glucose levels greater than 180. -There was an order for Jardiance (used to treat elevated blood glucose levels) 25mg take 1 tablet every morning. -There was an order for lantus (a long-acting insulin used to treat elevated blood glucose levels) inject 12 units at bedtime. -There was an order for levetiracetam (used to treat seizures) 500mg take 1 tablet twice daily. -There was an order for levothyroxine (used to treat low thyroid levels) 100mcg take 1 tablet every day. -There was an order for a lidocaine patch (used to treat pain) 5% apply 1 patch topically to the hip once daily and may wear up to 12 hours. -There was an order for melatonin (used to treat sleep problems) 3mg take 2 tablets at bedtime. -There was an order for metoprolol extended release (ER) (used to treat high blood pressure and manage heart failure) 25mg take 1 tablet daily. -There was an order for potassium chloride ER (used to treat low potassium levels) 10meq take 1 tablet daily. -There was an order for rosuvastatin (used to	D 349	Monitoring Procedures The Manager will ensure that regular chart audits are completed to verify that the tracking sheet is being used accurately and that all medication orders remain up to date. Audit findings will be reviewed during monthly Quality Assurance (QA) meetings to ensure sustained compliance. The LPN and RN will conduct random weekly spot checks of the Medication Administration Records (MARs) to verify consistency with physician orders.	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 349	Continued From page 33 treat elevated cholesterol levels) 40mg take 1 tablet at bedtime. -There was an order for senokot-s (used to treat constipation) 8.5mg-50mg take 1 tablet twice daily. -There was an order for acetaminophen (used to treat mild pain and fever) 325mg take 2 tablets twice daily as needed for pain/fever. -There was an order for anti-diarrheal (used to treat loose stools) 2mg take 2 tablets for initial occurrence of diarrhea and take 1 tablet after each loose stool with a maximum of 4 tablets in 24 hours. -There was an order for cranberry (a supplement used to treat a urinary tract infection) 450mg take 1 tablet every day as needed for a urinary tract infection. -There was an order for diphenoxylate-atropine (used to treat diarrhea) 2.5-0.025mg take 1 tablet four times daily as needed for diarrhea. -There was an order for nitroglycerin (used to relax blood vessels, treat chest pain, and reduce the heart's workload) 0.4mg place 1 tablet under the tongue every 5 minutes up to 3 doses as needed for chest pain then call the physician. -There was an order for ondansetron (used to treat nausea and vomiting) 4mg take 1 tablet every 8 hours as needed for stomach. -There was an order for refresh tears (used to treat dry eyes) 0.5% place 2 drops into affected eyes every 4 hours as needed for dry and itching eyes. Review of Resident #1's record revealed there were no six-month medication orders and treatments reviewed or signed by Resident #1's physician. A request for Resident #1's six-month signed physician's orders was made on 07/14/26 at	D 349		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 349	Continued From page 34 12:20pm and was not provided by the survey exit. Interview with the Resident Care Coordinator (RCC) on 07/14/26 at 4:30pm revealed: -Resident #1 saw a PCP in another city. -The facility's contracted nurse was responsible for keeping up with when the six-month physician's orders were due and taking them to the PCP's office to drop them off to be reviewed and signed. -She thought Resident #1's six-month physician's orders were not transported to the PCP's office because Resident #1 did not see a local PCP. -There was no staff at the facility designated to follow-up to make sure the residents' medication and treatment orders were up to date. -She faxed Resident #1's medication orders list to Resident #1's PCP today (07/14/26) and had not received the six-month orders back yet. Refer to the interview with the Manager on 07/15/26 at 10:15am. Refer to the interview with the Administrator on 07/16/26 at 10:42am. Attempted telephone interview with Resident #1's primary care provider (PCP) on 07/14/26 at 4:26pm was unsuccessful. 2. Review of Resident #2's current FL2 dated 11/10/25 revealed diagnoses included hypertension, anemia, spinal stenosis and glaucoma. Review of Resident #2's physician's medication orders dated 11/10/25 revealed: -There was an order for buspirone (used to treat anxiety) 15 mg take 1 tablet twice daily. -There was an order for Eliquis (used to treat	D 349		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 349	Continued From page 35 blood clots) 5mg take 1 tablet twice daily. -There was an order for ferrous sulfate (used to treat anemia) 325mg take 1 tablet daily. -There was an order for gabapentin (used to treat pain) 100mg take 1 tablet three times daily. -There was an order for latanoprost eye drops 0.005% (used to treat glaucoma) one drop in eyes at bedtime. -There was an order for memantine (used to treat dementia) 10mg take 1 tablet twice daily. -There was an order for nervive dietary supplement (used to treat nerve pain) 1 tablet three times daily. -There was an order for olanzapine(used to treat restlessness) 2.5mg take 1 tablet daily. -There was an order for senna (used to treat constipation) 8.6mg take 1 tablet at bedtime. -There was an order for tamsulosin (used for prostate health) 0.4mg take 2 capsules daily. -There was an order for Therems (a vitamin supplement) take 1 tablet daily. -There was an order for ultimate colon care (used to treat constipation) take 1 tablet daily. -There was an order for vitamin C (a dietary supplement) 500mg take 1 tablet daily. -There was an order for Vitamin D3 (a dietary supplement) 400 units take 1 tablet daily. -There was an order for tramadol (used to treat pain) 50 mg take 1 tablet daily as needed. -There was an order for (used to treat) mg take 1 tablet twice daily. -There was an order for (used to treat) mg take 1 tablet twice daily. Review of Resident #2's record revealed there were no six-month medication orders and treatments reviewed or signed by Resident #2's physician. Interview with the Manager on 07/14/26 at	D 349		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 349	Continued From page 36 2:30pm revealed she could not locate any six-month medication orders and treatments reviewed or signed by Resident #2's physician since the one signed on 11/10/25. Refer to the interview with the Manager on 07/15/26 at 10:15am. Refer to the interview with the Administrator on 07/16/26 at 10:42am. _____ Interview with the Manager on 07/15/26 at 10:15am revealed: -The facility's contracted registered nurse (RN) was responsible for keeping up with when residents needed new six-month physician's orders reviewed and signed. -She knew management failed to follow up and made sure six-month orders were completed for residents. -A new RN was hired on 07/13/26 but she did not have time to review the resident records yet to see what needed updating. Interview with the Administrator on 07/16/26 at 10:42am revealed: -She was not aware the six-month physician's orders were not up to date in the residents' records. -The former RN was responsible for reviewing resident records and made sure they were up to date. -She would have discovered the six-month physician's orders were not reviewed and signed by PCPs if she had completed chart audits, but she had some health issues and was out of work for about 6 weeks and returned to work approximately 2 weeks ago. -She "trusted it was all being done" while she was on leave.	D 349		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE