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	HAL026052	A. BUILDING: _____ B. WING _____	08/13/2026

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VALLEY PINES ADULT CARE	2521 MURIEL DRIVE FAYETTEVILLE, NC 28306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure section conducted an annual survey on August 12-13, 2026.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure the facility was free from hazards related to unsecured oxygen (O2) cylinders in two resident's bedrooms that were not stored in an O2 crate to prevent them from tipping over. The findings are: According to the National Fire Protection Association (NFPA) all standing oxygen (O2) cylinders must be securely chained, strapped, or racked to prevent falling or physical damage. Observation of a resident room #5 on 08/12/26 at 8:25am revealed there were 4 unsecured O2	D 079		

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cylinders that were not stored in an O2 crate and did not have green tags setting beside the television stand at doorway.

Observation of the warning label on the O2 cylinder in resident room #5 revealed:
-It was a high-pressure gas cylinder.
-Do not abuse cylinder; may cause failure and injury, or loss of life.
-Keep cylinder out of reach of children.

Interview with the resident in room #5 on 08/12/26 at 8:25am revealed:
-The O2 cylinders belonged to her previous roommate.
-The resident's roommate passed away a few years ago, she could not remember what year.

Observation of resident room #9 on 08/12/26 at 8:33am and 8:50am revealed:
-There were 5 unsecured O2 cylinders beside a chest of drawers.
-There were 4 O2 cylinders, 3 of the O2 cylinders had green tags located between the resident's bed and a bedside table.
-There were two residents in the room, one used a wheelchair.

Interview with a resident in room #9 (there were two in the room) on 08/12/26 at 8:45am revealed:
-He had been on O2 since he was admitted to the facility one year ago.
-He was on 4 liters continuous oxygen via nasal cannula.
-He used an O2 concentrator when he was in his room and O2 cylinders when he left his room.
-His O2 cylinders were stored in his room.

Interview with the personal care aide (PCA) on 08/12/26 at 8:50am revealed:

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D 079	Continued From page 2 -She did not know how the O2 cylinders were supposed to be stored. -She did not know what the green tag on top of the O2 cylinder meant. -She was not concerned about the O2 cylinders getting knocked over. Interview with the Resident Care Coordinator (RCC) on 08/12/26 at 11:16am revealed: -She did not remember if there was a policy related to storage of O2 cylinders. -She was responsible to ensure the residents had enough O2 cylinders and she switched out the cylinders when needed. -She notified the O2 supply company when the resident needed more O2 cylinders. -She did not know that the O2 cylinders needed to be stored in a crate. -The green tag at the top of the cylinder meant that the O2 cylinder was full. -She would have been concerned if the O2 cylinder was knocked over that it would leak. -She would not be concerned about anything else if the O2 cylinder was knocked over. -The O2 tanks had been in room #5 since the resident passed away in 2023. -She had not called anyone to pick up the O2 cylinders. -She was responsible to ensure the O2 cylinders were picked up when not needed. Observation of resident room #9 on 08/12/26 at 2:19pm revealed there was an empty O2 crate sitting on the floor at the foot of his bed that had not been there previously. Observation of the resident room #5 on 8/13/26 at 7:30am revealed the 4 unsecured O2 cylinders were not stored in an O2 crate.	D 079		

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D 079	Continued From page 3 Second interview with the RCC on 08/13/26 at 10:13am revealed: -She had secured the resident's O2 cylinders in a crate yesterday, 08/12/26. -She did not know what to do with the 4 O2 cylinders from the resident that had passed away. -She did not know what O2 company to call to pick them up. -She was responsible to ensure the O2 cylinders were secured properly. Interview with the Administrator on 08/12/26 at 9:30am revealed: -The O2 cylinders in room #5 belonged to a resident that passed away several years ago. -He did not call the O2 company to pick up the O2 cylinders. -He did not know what to do with the O2 cylinders. -The O2 cylinders were in her closet until it was cleaned recently. -He did not know of anything that could happen to the O2 cylinder if knocked over other than leaking. Telephone interview with the facility's O2 supply company on 08/12/26 at 2:24pm revealed: -The company provided crates to store the residents O2 cylinders in. -The O2 cylinders should be stored upright in a crate and strapped down. -The O2 cylinders should not be stored in cramped areas where they could become damaged or knocked over. -If a O2 cylinder falls over, the top of the tank could burst and O2 leak out. -The valve on top could break off when the O2 cylinder was knocked over, which could potentially make the O2 cylinder propel like a missile.	D 079		

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D 079	Continued From page 4 -When the valve of the O2 cylinder becomes dislodged the O2 which was under pressure tried to escape and this was why the O2 cylinder would propel like a missile. _____ The facility failed to ensure a hazard-free environment was maintained for the residents related to unsecured oxygen cylinders stored in two residents' rooms that were not stored in an O2 crate to prevent them from tipping over which could cause an explosion and propel the O2 cylinder like a missile if overturned. This failure was detrimental to their health, safety and welfare, and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/13/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED September 27, 2026.	D 079		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities.	D 113		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) in resident's bathrooms as evidenced by 5 of 5 fixtures with water temperature ranging from 120°F to 124°F.

The findings are:

Observation of the facility's water temperatures on 08/12/26 from 8:30am to 8:50am in the residents' bathrooms and shower room revealed:
-In the women's bathroom, the hot water temperature of the sink was 122°F.
-In the men's bathroom, the hot water temperature in the sink was 120°F.
-In a shower room, the hot water temperature in the shower was 122°F.
-In a shower room, the hot water temperature in the bathtub was 122°F.
-In a bathroom labeled male/female, the hot water temperature in the sink was 124°F.

Interview with the personal care aide (PCA) on 08/12/26 at 09:00am revealed:
-No one had complained about the hot water being too hot.
-When she helped the residents shower she adjusted the water temperature for the residents.

Interview with the Resident Care Coordinator (RCC) on 08/12/26 at 09:30am revealed:
-She was responsible for checking the hot water temperatures.
-She checked the fixtures the residents used monthly.

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-She did not keep hot water temperature check logs.
-The last time she checked the hot water temperatures was on 08/06/26, they were 4 degrees high, 118°F to 120°F.
-She did not notify anyone that the hot water temperature on 08/06/26 were out of range.
-She was supposed to notify the Administrator when hot water temperatures were out of range but she did not notify him.
- No one had complained that the water was too hot.
-She was not sure if there was a facility policy on checking hot water temperatures.

Interview with a maintenance staff member on 08/12/26 at 11:50am revealed:
-He was called today, 08/12/26 to come and adjust the hot water temperature.
-The three hot water tanks were set on 125°F and he adjusted them to 120°F.
-He did not perform water temperature checks in the facility.
-He only adjusted the water temperature when the facility asked.

Interview with the Administrator on 08/12/26 at 12:00pm revealed:
-The RCC notified him that the hot water temperatures were elevated and that the maintenance worker had been notified to adjust the water temperatures.
-He was also able to adjust the hot water temperatures when needed.
-He was concerned that a resident could burn themselves if the hot water was too hot.
-There were several residents that did not require assistance when showering.

Observation of water temperatures on 08/12/26

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from 3:00pm to 3:14pm in the residents' bathrooms and shower room revealed:
-In the women's bathroom, the hot water temperature in the sink was 120°F.
-In a shower room, the hot water temperature in the shower was 120°F.
-In a shower room, the hot water temperature in the bathtub was 120°F.
-In a bathroom labeled male/female, the hot water temperature in the sink was 120°F.

Interview with a medication aide (MA) on 08/12/26 at 4:00pm revealed:
-She had not heard anyone complain that the water was too hot.
-There were two residents that did not require assistance showering.

Observation of water temperatures on 08/13/26 from 7:45am to 8:00am in the residents' bathrooms and shower room revealed:
-In the men's bathroom, the hot water temperature in the sink was 98°F.
-In a shower room, the hot water temperature in the shower was 98°F.
-In a shower room, the hot water temperature in the bathtub was 98°F.

Interview with a resident on 08/13/26 at 8:10am revealed:
-He did not require assistance when he took a shower.
-The hot water this morning was not as hot as it usually was.
-It felt better today, 08/13/26 because it was not as hot which made it easier to adjust the water temperature.

Interview with a second resident on 08/13/26 at 8:15am revealed:

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D 113	Continued From page 8 -He was able to shower without any assistance. -He had a shower yesterday, 08/12/26. -He did not have any issues adjusting the temperature of the shower. -The water was always hot and he adjusted the temperature by adding cold water. Second interview with the RCC on 08/13/26 at 10:13am revealed: -When the hot water temperatures were out of range, she called the facility maintenance staff member and he would adjust the hot water temperature. -The hot water temperature was adjusted on 07/07/26 because the hot water temperatures were too hot. -The facility did not have a policy related to checking hot water temperatures. Telephone interview with the Administrator on 08/13/26 at 11:05am revealed: -The RCC was responsible for performing the hot water temperature checks. -He did not know that the hot water temperatures were high last week. -His expectation was to be notified when the hot water temperatures were out of range. -He had last turned the hot water temperature down on the hot water heaters in June 2026. -He did not know of a facility policy related to performing hot water temperature checks. -The facility was supposed to document the hot water temperature checks on a log. Attempted telephone interview with the facility's contracted primary care provider (PCP) on 08/12/26 at 2:25pm was unsuccessful.	D 113		

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D 306	Continued From page 9	D 306		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served at the breakfast meal in addition to other beverages. The findings are: Observations of the breakfast meal service on 08/13/26 between 9:15am and 9:45am revealed: -There were 8 residents present for the breakfast meal service. -The residents were served milk and juice. -One resident was served only water because he did not drink any other liquids. -Another resident was served water in addition to the milk and juice in his room. Interview with a resident on 08/13/26 at 10:13am revealed: -Water was served with meals if the residents wanted water. -Water was mainly served at lunch and dinner. Interview with a second resident on 08/13/26 at 10:11am revealed:	D 306		

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-The residents had access to water throughout the day, anytime they wanted it.
-Water was not usually served with meals unless it was requested.
-She did not want water because it did not taste very good.

Interview with a personal care aide (PCA) on 08/13/26 at 9:54am revealed:
-All residents were usually served water in addition to milk and juice at every meal.
-Residents were not served water today because the water cups had cracks in them and they were awaiting the arrival of new water cups.
-The facility had other cups, but it would look more uniform if all the cups were the same.
-The residents had access to water all day.

Interview with the Resident Care Coordinator (RCC) on 08/13/26 at 10:26am revealed:
-Residents were supposed to be served water with every meal.
-The residents were not served water with breakfast because she became distracted while preparing breakfast.
-Residents were usually served water with every meal.
-There was no issue with cups being cracked or the need for new cups.

Observation of the facility on 08/13/26 at 11:22am revealed the medication aide (MA) returned to the facility with a new pack of approximately 12 clear cups.

Second interview with the RCC on 08/13/26 at 12:30pm revealed:
-The PCA told the staff member to buy more cups when she should not have.
-She stored the new cups in her office instead of

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D 306	Continued From page 11 putting them in the kitchen because the facility did not need new cups. -There were cups available for water for the residents. -She became distracted at breakfast and forgot to serve water to the residents. Telephone interview with the Administrator on 08/13/26 at 11:05am revealed: -Water was served to residents with every meal. -He served water to the residents every time he prepared a meal for the residents. -He was not aware water was not served to the residents at breakfast. -He did not know why water was not served to the residents at breakfast. -Water was supposed to be served to the residents at every meal. Attempted interview with the MA on 08/13/26 at 12:30pm was unsuccessful.	D 306		
D 377	10A NCAC 13F .1006 (a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication room door was closed and locked in the Assisted Living (AL), and that the medication cart was locked when not under the direct supervision of a medication aide (MA).	D 377		

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D 377	Continued From page 12 The findings are: Observation of the medication room and medication cart on 08/12/26 from 09:00am to 09:10am revealed: -The medication room door was open. -The medication cart was in the medication room. -The medication cart was unlocked and the medication room key and medication cart key were laying on top of the medication cart. -The sliding window in the medication room was opened and accessible to the living room. -There were 3 bottles of Geri Lanta (Geri Lanta was used to treat indigestion), 1 box of Refresh Eye Drops (Refresh Eye Drops were used to treat dry eyes), and 1 box of Thera Tears solution 0.25% (Thera Tears were used to treat dry eyes) located on top of the medication cart. -Three residents walked by the open medication room. -The personal care aide (PCA) walked by the open medication room. Interview with the Administrator on 08/12/26 at 9:10am revealed: -He was working as the medication aide (MA) today. -He forgot to lock the medication cart and pick up the keys when he left the medication room. -The facility had always kept some medications on top of the medication cart. -He did not have any concerns that a resident would enter the medication room. Interview with the Resident Care Coordinator (RCC) on 08/13/26 at 10:13am revealed: -She could not locate a facility policy on medication storage. -The MA who was working was responsible for	D 377		

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D 377	Continued From page 13 ensuring that the medication cart was locked. -Controlled Substances were supposed to be stored under two locks. Telephone interview with the Administrator on 08/13/26 at 11:05am revealed: -He was not sure if the facility had a policy related to medication storage. -Controlled Substances were to be stored under double locks. -He was concerned that that a resident or staff could have gone into the medication room and medication cart and taken medications. -The medication room door should be closed because medications were stored in the medication room, medication refrigerator, and on top of the medication cart. Attempted telephone interview with the facility's contracted primary care provider (PCP) on 08/12/26 at 2:25pm was unsuccessful.	D 377		