STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 08/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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 Warren County Department of Social Services (DSS) conducted an annual and follow-up survey, and a complaint investigation from 08/05/26 to 08/07/26.	D 000		
D 075	10A NCAC 13F .0306 (a)(2) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no persistent and recurring odors that are considered by the residents to be unpleasant; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an environment free from unpleasant odors. The findings are: Review of an electronic message received by the surveyor from a representative from the county health department dated 08/06/26 at 4:31pm revealed: -An inspector made a site visit to the facility on	D 075		

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D 075	Continued From page 1	D 075		

06/26/26.
-When she exited her vehicle in front of the facility, she could smell sewage.

Observation of the facility on 08/05/26 at 8:00am revealed a strong sewage odor was detected in the parking lot outside the facility.

Observation of the shower room in the special care unit (SCU) on 08/05/26 at 8:30am revealed a strong sewage odor was detected in the shower room when the door was opened.

Observation of a resident's room in the SCU on 08/06/26 at 11:40am revealed:
-When the door to the resident's room was opened, there was a strong sewage odor.
-The room was located on the backside of the facility.
-The toilet was clean and did not appear to have been used.
-The tub inside the bathroom had not been used and had debris around the drain.

Interview with a resident on 08/06/26 at 5:10pm revealed:
-He had "smelled" a bad smell in the SCU; he did not recall when he smelled it.
-The odor was not present all the time, but when it was present, it was bad.
-He would not want to smell that odor all the time.

Confidential interview with a staff member revealed:
-There had been a sewer odor in the facility.
-The odor was worse in the SCU.
-The sewer odor was also present outside the facility.

Interview with the SCU Coordinator (SCC) on

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D 075	Continued From page 2 08/07/26 at 9:41am revealed she had not smelled a sewer odor in the SCU but had smelled a sewer odor in the assisted living (AL) unit. Interview with the Administrator on 08/07/26 at 3:24pm revealed: -When a resident's toilet backed up, there would be a sewage odor inside the facility until the toilet was unclogged. -The toilet would be unclogged and operational again within no more than five hours.	D 075		
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: Based on observations, interviews, and record reviews, the facility failed to provide a safe and clean environment free of hazards related to live roaches in the facility. The findings are: Observation of the shower in the special care unit (SCU) on 08/06/26 at 12:18pm revealed there	D 079		

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D 079	Continued From page 3 was a live roach on the floor of the shower. Observation of the assisted living (AL) hallway on 08/06/26 at 3:30pm revealed there was a live roach in the hallway. Review of the facility's environmental health inspection report conducted by the local department of health dated 04/15/26 revealed: -The facility received a score of 98. -There was a half a point deduction for pest presence and effective pest control measures. -The observation was a bug in a resident's bathroom. -The Administrator told the inspector the pest control company had just sprayed the day before, the pest control company would come more frequently during warmer weather and the pest control company sprayed every two weeks. Review of the facility's contracted pest control company's invoices for April 2026 to July 2026 revealed: -The pest control company serviced the facility once a month. -The pest control technician did a complete walk through of the building each visit and asked every available staff member about any pest issues they were aware of. -There was a note on the invoice dated 06/25/26, the kitchen roaches at the reach in cooler and along the dish line wall were treated. -There were no service notes on the other invoices. Interview with a resident who resided in the AL on 08/07/26 at 9:05am revealed: -He saw live roaches in his room a month ago. -He did not report them to anyone; he just killed them.	D 079		

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D 079	Continued From page 4 -He saw the pest control company spraying in the hallway about a year ago. Interview with a second resident who resided in AL on 08/07/26 at 11:28am revealed: -She saw roaches in her room frequently. -She had seen roaches "just the other day." -Sometimes the roaches were tiny, and sometimes they were grown. Interview with a third resident who resided in the AL on 08/07/26 at 9:06am revealed: -He saw multiple live roaches in the hallway a couple of days ago. -He saw the pest control company spraying the hallways and his room about a month ago. -He did not report the live roaches to the staff. -He did not see dead roaches. Interview with a personal care aide (PCA) on 08/07/26 at 8:55am revealed: -She had seen dead roaches outside of the facility in the corners of the doors. -None of the residents had complained to her about live roaches. Interview with the housekeeper on 08/07/26 at 9:10am revealed: -He had seen a small roach in the hallway in the AL yesterday; he killed it. -He saw live roaches about once every two weeks. -He saw them in the hallways, never in residents' rooms. -He saw the man from the pest control company walking through the facility last month. -He did not know if the man sprayed inside. -He reported any live roach sightings to the Maintenance Director. -Staff and residents had never reported to him	D 079		

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about seeing roaches.

Interview with the Maintenance Director on 08/07/26 at 8:40am revealed:
-The pest control company sprayed the building every so often.
-He saw the pest control company spraying inside the building but he was not sure exactly where because he did not interact with them.
-He had seen live roaches in the facility.
-He last saw one in a resident's room; he could not recall when.
-Staff told him they saw roaches; just about everyone had seen live roaches.
-He told the Administrator when he saw live roaches and dead ones.
-He saw more dead roaches after the pest control company sprayed.

Interview with the Resident Care Coordinator (RCC) on 08/07/26 at 10:10am revealed:
-She had not seen any live or dead roaches in the facility recently.
-When she first started working at the facility in May 2026, she saw live roaches but she could not recall where she saw them.
-The pest control company sent someone to spray two or three weeks ago; she did not talk to him.
-None of the residents, family or staff had complained or reported seeing live roaches to her.

Interview with the Executive Director (ED) on 08/07/26 at 11:55am revealed:
-The pest control company sprayed once a month but if they saw roaches or other bugs in the facility, he would come out twice a month.
-The man who came from the pest control company and sprayed usually spoke to the staff

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or her when he came.
-She knew the man from the pest control company sprayed the kitchen, the medication room, the offices, the common areas, the bathrooms, and the shower rooms but she was not sure about the resident rooms.
-He would ask her if there were problems and she would tell him if there were.

Interview with the Administrator on 08/07/26 at 1:50pm revealed:
-The pest control company treated for roaches by spraying the facility monthly.
-The man from the pest control company would ask staff if they saw roaches and where they were seen.
-He would put on his monthly reports where he sprayed.
-They had decluttered residents' rooms and done deep cleaning so the pest control company could spray after they were cleaned; it was an ongoing process.
-She had concerns about the number of live roaches that were seen in the facility; the roaches had gotten better but there was still a lot of sightings.
-She had seen live roaches in the building herself.
-Some of the staff and residents had told her they saw live roaches in the common area Sunday evening, 08/02/26.
-She did not want the residents to get upset because there were roaches in the building or in their rooms; she wanted to get rid of the roaches.
-She did not like having roaches in the building.
-She decided on Tuesday, 08/04/26, she was going to get a pest control company that specialized in roaches to help get rid of the roaches.

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D 079	Continued From page 7 Attempted telephone interview with a representative from the facility's contracted pest control company on 08/07/26 at 4:01pm was unsuccessful. Attempted telephone interview with the inspector from the local department of health on 10:00am was unsuccessful.	D 079		
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the plumbing equipment was maintained in a safe and operating condition to prevent the septic system from overflowing. The findings are: Review of the facility's current license effective through 12/31/26 revealed the facility was	D 105		

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D 105	Continued From page 8 licensed for 66 assisted living (AL) and 20 special care unit (SCU) residents. Review of a septic company's invoice dated 06/13/24 revealed: -Service was to repair broken piping to pumps that was caused by foreign objects being present in the pump tank. -Upon arrival, the pumps were running nonstop and failing to pump down effluent inside the tank. -Wipes, socks, adult incontinence briefs, plastic, and other foreign material in the pump tank caused both pumps to seize up and break the existing piping. -The entire tank (roughly 10,000 gallons) was pumped down in order to make the necessary repairs to get the system operational. -Upon departure both pumps were pumping effectively. -Foreign material such as socks, adult incontinence briefs, plastic, and wipes should not be deposited into the pump tank under any circumstance; this issue would continue to happen until the employees/residents stopped flushing these items. -An estimate would be provided to install a 1500-gallon septic tank with a filter to potentially keep debris out of the pump tank moving forward. -An estimate was provided for complete replacement of the existing system due to the deterioration of the existing pump tank and components. Review of an electronic message received by the surveyor from a representative from the county health department dated 08/06/26 at 4:31pm revealed: -An inspector made a site visit to the facility on 06/26/26. -When she got out of her vehicle in front of the	D 105		

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facility, she could smell sewage.
-She made contact with the Facility Manager and told her she was there to investigate a complaint.
-The Facility Manager told her that they had not noticed any problems with the system.
-The Facility Manager told her it had not been that long since they had the tanks pumped out.
-The maintenance staff, the Facility Manager, and one additional employee took her to where the tank was located.
-Once they were outside, she saw that the grass around the tank was very tall and asked why the grass was not being cut in that location.
-She was told it was because the ground was too wet.
-She evaluated what was occurring with the sewage and tried to determine how much area was covered with sewage.
-She showed them where the sewage was coming out of the tank and told them that it needed to be fixed.

Review of the Notice of Intent to Suspend or Revoke Permit dated 07/28/26 provided by the local health department revealed:
-Sewage was observed leaking from the septic tank.
-The letter notified the management of the facility that, based on the violations of the laws and rules, the health department intended to suspend the facility's permit 30 days from the date of the notice.
-If the health department determined that all the violations had been corrected before 30 days had expired, the suspension would not go into effect.
-The document was signed by the Executive Director and the Environmental Health Specialist.

Review of a document titled "Risks of Untreated Wastewater" provided by the local health

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D 105	Continued From page 10 department revealed: -Care facilities generated much higher volumes and stronger concentrations of sewage waste than typical residential homes. -Untreated sewage in a care facility exposed fragile elderly residents to severe waterborne bacteria, viruses, and parasites which increased the risk of acute gastrointestinal illnesses, rapid dehydration, dangerous skin and wound infections, and life-threatening systemic complications like sepsis. -Untreated sewage increased the exposure to pathogens like E. coli, Salmonella, and Campylobacter which could result in severe diarrhea, bloody stools, high fever, and painful abdominal cramps. -Raw sewage frequently carried viruses such as Hepatitis A and norovirus, causing severe liver or intestinal distress. -Dried or agitated sewage particles released harmful bacteria and mold spores into the indoor air. -Hydrogen sulfide and methane emissions from backups caused headaches, dizziness, nausea, and chronic respiratory irritation. -Residents with chronic obstructive pulmonary disease (COPD) or compromised immune systems faced sharply elevated risks of severe respiratory decline. -Direct contact with contaminated water or surfaces introduced bacteria into open pressure ulcers or fragile skin. -Untreated bacterial entry into the bloodstream via infected wounds or severe gut infections rapidly triggered systemic inflammation, organ failure, and high mortality rates among residents. Observation of the facility on 08/05/26 at 8:00am revealed a strong sewage odor was detected in the parking lot outside the facility.	D 105		

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D 105	Continued From page 11 Observation of the electrical box at the back of the facility on 08/06/26 at 3:27pm revealed: -The box was located beside the septic tank. -There was a red light mounted on top of the electrical box; the light was not illuminated. -Inside the box were controls labeled as pump 1 and pump 2. -There was a small red light that indicated seal failure on pump 1 and a second small red indicator light for seal failure on pump 2; neither light was illuminated. Observation of the septic tank on 08/06/26 at 3:29pm revealed: -There was water moving across the ground beside the septic tank and running toward the wooded area at the back of the facility. -The grassy area around the septic tank was overgrown and had not been mowed. Interview with a resident who resided in room #27 on 08/05/26 at 8:23am revealed: -The toilet that connected room #27 and room #26 did not work. -The water was turned off to the toilet and sink. -The toilet would overflow if it was flushed when the water was turned on. -She had been going across the hall to use the toilet in resident room #11. -The bathroom in resident room #11 was smaller and she could not get her rollator walker in the smaller bathroom. -She would leave her rollator at the door and hold onto the door and wall to use the toilet. -She could wash up in the shower room down the hall. -The toilet had been broken for 5 days. Interview with a resident who resided in room	D 105		

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D 105	Continued From page 12 #26 on 08/05/26 at 8:30am revealed: -She had been going across the hall to use the toilet in resident room #11. -The bathroom in resident room #11 was smaller and she could not get her wheelchair in the smaller bathroom. -She would leave her wheelchair outside of the bathroom and hold onto the door and wall to use the toilet. -The toilet had been broken 5 to 7 days. Interview with a resident who resided in room #27 on 08/06/26 at 7:45am revealed: -She moved into the facility on 08/05/26. -The staff told her to use the bathroom in the residents' room across the hall. -They told her the bathroom in her room was broken. -They did not say how long she would have to use the bathroom across the hall. -She did not wake up to use the bathroom in the middle of the night yet. -She did not know if she could use the sink in her bathroom. Interview with a personal care aide (PCA) on 08/06/26 at 10:00am revealed: -The toilets did not work when she returned to work on Monday 08/03/26. -The residents were told to use the bathroom down the hall or use the bathroom in resident room #11. Interview with the Resident Coordinator (RCC) on 08/07/26 at 10:15 am revealed: -She was aware of the toilet not working and the Maintenance Director was working to resolve the issue. -The residents were instructed to use the hallway bathroom.	D 105		

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D 105	Continued From page 13 Observation of the shower room in the SCU on 08/05/26 at 8:30am revealed: -There was a strong sewage odor detected in the shower room when the door to the room was opened. -The floor of the shower was dry. -When checking the water temperature in the sink, the water was not draining from the sink. -Water began backing up into the shower when the water was running in the sink. Interview with a resident on 08/06/26 at 5:08pm revealed: -He took a shower in the SCU shower room one day last week, and the water backed up to his shins. -When he turned the water off, the water went back down. Interview with a medication aide (MA) on 08/06/26 at 2:38pm revealed: -The shower in the SCU backed up over a resident's feet while she was showering the resident. -The shower also backed up today, 08/06/26, over the soles of the resident's feet. Interview with a second MA on 08/06/26 at 3:14pm revealed: -One day last week, she did not recall the date, the shower backed up while she was showering a resident. -She reported the incident to someone, but she did not recall to whom. Interview with a third MA on 08/07/26 at 10:11am revealed the two residents' toilets were stopped up all the time, but she thought it was because the residents used too much toilet paper.	D 105		

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(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 105	Continued From page 14 Review of a maintenance work order on 08/06/26 that was dated 08/03/26 at 7:59pm revealed there were two residents' toilets in the SCU that were slow to flush and clogged. Observation of the bathroom in room #4 in the SCU on 08/05/26 at 8:34am revealed: -The toilet was full of water to the rim. -The toilet contained a small amount of toilet paper. -The water supply to the toilet was turned off at the back of the toilet. -A PCA turned the water on to flush the toilet. -The water began leaking around the base of the toilet, and the PCA immediately turned the water off. Interview with the housekeeper on 08/05/26 at 12:24pm revealed he had turned the water off to the toilet because water was leaking around the base of the toilet. Second observation of the bathroom in room #4 in the SCU on 08/05/26 at 2:42pm revealed: -There was a caution wet floor sign outside the bathroom door. -There was water on the floor around the base of the toilet. -The water supply to the toilet was turned off at the back of the toilet. -The toilet was full of used toilet paper and feces. Observation of the bathroom in room #4 in the SCU on 08/06/26 at 2:39pm revealed a resident was using the toilet. Second observation of the bathroom in room #4 in the SCU on 08/06/26 at 2:46pm revealed: -The toilet had a small amount of water at the	D 105		

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bottom and contained several wads of used toilet paper.
-The water supply to the toilet was turned off.
-There was a towel lying on the floor at the base of the toilet, and the towel was wet.

Observation of the bathroom in room #4 in the SCU on 08/07/26 at 8:25am revealed:
-There was a small amount of water at the bottom of the toilet.
-There was a blanket on the floor surrounding the base of the toilet, and the blanket was wet.

Based on observations and interviews, the resident who resided in room #4 was not interviewable.

Observation of the bathroom in room #6 in the SCU on 08/05/26 at 8:37am revealed:
-The toilet contained a small amount of toilet paper.
-When the toilet was flushed by a staff member, the water began filling the rim and overflowed onto the floor.
-The staff member then turned off the water supply to the toilet at the back of the toilet.

Observation of the bathroom in room #6 in the SCU on 08/06/26 at 7:11am revealed:
-The toilet had a small amount of water and one wad of toilet paper.
-There was a pile of wet blankets and towels on the floor.

Second observation of the bathroom in room #6 in the SCU on 08/06/26 at 5:06pm revealed:
-The toilet lid was closed.
-There were blankets on the floor surrounding the base of the toilet; the blankets were wet.

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D 105	Continued From page 16 Observation of the bathroom in room #6 in the SCU on 08/07/26 at 10:07am revealed: -The toilet lid was closed. -There were blankets on the floor surrounding the base of the toilet; one of the blankets was soaking wet. Interview with one of the residents who resided in room #6 in the SCU on 08/06/26 at 4:59pm revealed: -The toilet had been stopped up for "a bit." -She did not know what happened to the toilet. -There had been water on the floor around the toilet. -She had to go down the hall to use another bathroom. -She was uncomfortable having to use the bathroom down the hall. Interview with the second resident who resided in room #6 in the SCU on 08/06/26 at 5:03pm revealed: -The toilet was constantly stopped up, and there was water on the floor. -It had been going on for a while. -She thought the toilet needed to be fixed, and no one was doing anything about it. -She felt like she was being neglected. -She had not told anybody about the toilet because they were not going to do anything about it anyway. Interview with a MA on 08/06/26 at 2:38pm revealed the residents with clogged toilets were continent and needed to have access to a working toilet. Interview with the housekeeper on 08/06/26 at 7:06am revealed: -There were two toilets in the SCU and one toilet	D 105		

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in the AL that were backing up because the septic system needed to be pumped.
-The septic system had been pumped but had not been pumped completely empty; he did not recall when it had been pumped.
-The toilets should have been functioning properly once the septic system was pumped "good."

Interview with the housekeeper on 08/07/26 at 8:29am revealed:
-Both of the toilets in the SCU were "snaked" (a cable was run down through the toilet to clear the toilet) on 08/05/26, and there was nothing in the toilets to cause them to back up.
-The corporate Maintenance Director "snaked" the toilets on 08/06/26; the toilet lines were clear, but the toilets were still overflowing.

Interview with the Maintenance Director on 08/06/26 at 7:52am revealed:
-He had been working at the facility for less than a year.
-About six months ago, there was a problem with several of the toilets overflowing, but he thought it was because the toilets were clogged.
-The septic system was pumped down at that time, and approximately one month later, the toilets were overflowing again.
-A representative from a septic system company was at the facility on 08/05/26 and stated the septic tanks needed to be pumped all the way down and the pumps needed to be repaired.
-The pumps had been broken for approximately three months, to the best of his knowledge.

Telephone interview with a representative from a plumbing company on 08/06/26 at 9:10am revealed:
-He often had to repair toilets at the facility as well as doing other plumbing work.

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D 105	Continued From page 18 -Residents flushed items down the toilets that would clog up the toilets. -Another problem was the lines out of the facility did not have enough slope which could cause the toilets to back up quicker. -He had not been called out to work on any toilets in the facility this week, 08/05/26. -He would usually be able to go to the facility the following day when he received a call. Telephone interview with a representative from a septic company of 08/06/26 at 9:22am revealed: -Within the last 1-2 years, he had completed an assessment of the facility's septic system and what needed to be done for the system to properly function. -He told the Maintenance Director the pumps had failed and needed to be repaired. -He had requested to speak with Management of the facility but only spoke with the Maintenance Director. -He was asked by the facility to pump off the septic system, and he again told them that the pumps needed to be repaired. -The facility "keeps putting a band-aid on, instead of fixing it." -On 07/08/26, he pumped off 5 loads of septic, and the tanks were still full. -On 07/28/26, the facility contacted him to pump the septic system again, but he could not because he had not been paid for the work he had completed on 07/08/26. -The facility had floor drains in the kitchen, and if the septic system was not pumped, the septic could back up into the kitchen. -If water was backing up in the shower, it was because when water was running and the septic tanks were full, the water would have nowhere to go and would come back into the facility through the floor drains.	D 105		

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D 105	Continued From page 19 -He had been performing septic system work for over 30 years, and he was concerned that the management of the facility did not understand how serious the problem was or what needed to be done to correct it. -It was very important to get the pumps repaired so the septic system could function correctly. -There were many diseases that could come from the septic system, and he was concerned about the residents and staff. Telephone interview with a representative from another septic company on 08/06/26 at 9:59am revealed: -He had not pumped the septic tanks at the facility for several years. -He was at the facility to assess what the needs were on 08/04/26 and the septic tanks were "slam full" and the pumps were not working. -The septic was currently running out the sides of the tank and into the woods. -If water was draining out of the sink slowly, it was because the septic tank was full and there was nowhere for the water to go. -The floor drain was at the lowest point in the bathroom and that was where the water would back into first. -Fecal matter could come back into the facility through the floor drains. -The facility needed to be on a pump and haul system until the pumps were repaired. -He thought the septic tank would need to be pumped off daily until the pumps were repaired. -The alarm system was not working on the septic tank to notify the facility the septic tanks were full. -He was concerned the residents were in contact with contaminated water because the water should be going away from the facility, not back into the facility. -He could tell the septic tank issue had been	D 105		

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ongoing for several months based on the height of the grass/weeds that had not been mowed because the area was wet.
-The facility's septic system was very old.

Telephone interview with a representative at the local health department on 08/06/26 at 10:14am revealed:
-A complaint was received by the health department in June 2026 related to the septic system surfacing (coming up to or appearing on the ground surface).
-The facility was on the county's sewer system.
-Waste water from the facility went into a septic tank.
-Pumps in the septic tank then pumped the wastewater out of the tank, through septic pipes, to the highway, where it connected to the county's sewer system and was disposed of.
-Facility staff were told in June 2026 to have the septic system repaired.
-It was known in June 2026 that the pumps were not working, or the wastewater would have been pumped out of the septic tanks to the county sewer system.
-In July 2026, the food inspector was at the facility, and the facility was told that the septic tanks needed to be pumped out frequently until the septic system was repaired; frequently meant whatever was needed to keep the wastewater from draining onto the ground.
-She was not sure if the issue was the pump control panel not working, a clog in the line, or if the pumps were not pumping the wastewater out of the septic tanks.
-She was not aware that the floor drains had water backing up.
-If water was backing up in the shower, it was a sewage issue.
-All water that left the facility was considered

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sewage, and water backing up into the shower would be considered sewage.
-If toilets were overflowing and the toilet was not clogged, it was because the septic system was full.
-The way the system worked was that all plumbing was tied together to exit the facility into the septic tank.
-Septic tanks held a certain amount of waste, and a float inside the tank rose as the waste level increased.
-Once the float reached a certain point, it would activate the pump to pump the sewage out of the tank to the county's septic system and then turn off.
-If the pumps did not work, the float would continue to rise, which would then activate an alarm, both audible and visual, to alert the facility that there was a problem.
-Even after the alarm was activated, the facility would have time to resolve the issue before the septic system started leaking out.
-The sewage would continue to back up and find a "way out," either through leaking and/or backing up into the facility.
-The kitchen waste water, because it contained grease, food debris, and oil, carried bacteria and germs that residents would be exposed to if the water was backing up into the facility.

Interview with the Executive Director on 08/06/26 at 11:11am revealed:
-A representative from the county health department was at the facility on 07/28/26 due to a complaint about the septic system going into the creek.
-The health department representative could see water seeping out of the side of the septic tank.
-The health department representative walked through the woods and followed the wastewater

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running out of the septic tank.
-They were told by the health department representative that the septic system needed to be repaired.
-A representative from a septic company came to the facility on 07/28/26, took the top off the septic tank, and stated that pumping the tank down halfway would not work and that the tank needed to be pumped empty to fix the leaking tank.
-She gave the information provided by the septic company to the Administrator and the Owner.
-The septic tank was last pumped on 07/08/26.
-A regional maintenance staff member was at the facility today, 08/06/26, and snaked the three toilets that were backing up, and none of the toilets had anything clogged in the lines.
-She did not know the shower in the SCU was backing up until today, 08/06/26.

Interview with the facility's primary care provider (PCP) on 08/06/26 at 11:54am revealed:
-She was not aware that the facility was having any septic system issues.
-If water was backing up and/or toilets were clogged, it was not sanitary and placed the residents at risk.
-If residents were sitting on a toilet that was full, and any open area comes into contact with the sewage, the resident was at risk for a bacterial infection and urinary tract infections.
-If a resident was standing in the shower and the shower was backing up onto the resident's feet, any opening, even a crack, would be a portal and would place the resident at risk for an infection.

Telephone interview with a representative from the septic system pump manufacturer on 08/06/26 at 3:59pm revealed:
-It had been at least five years or more since he had been at the facility to check the pumps.

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-The facility's septic tank had two pumps.
-Someone at the facility, such as the Maintenance Director, should have been checking the pumps monthly to ensure the pumps were working correctly.
-If neither pump was working, the pumps had probably sucked something into the pump that caused the pump to stop working.
-The facility should have had an alarm in place with a light and a horn to alert the facility when the water level was high and the pumps were not working.
-The septic tanks needed to be pumped out daily until the pumps were repaired and the septic system was working.

Interview with the Maintenance Director on 08/07/26 at 8:48am revealed:
-He did not know anything about the facility's sewage pumps until the plumber told him the pumps were not working about 4-5 months ago.
-He told the Administrator and Owner the pumps were not working.
-He had not been told there were any problems with the toilets in the SCU until Monday, 08/03/26.
-At other times, a toilet might be clogged, but once it was plunged, it would be fine.

Interview with the SCU Coordinator (SCC) on 08/07/26 at 9:41am revealed:
-She had been working at the facility for about 1.5 years.
-There had been problems with the two residents' toilets before, but usually the housekeeper and/or Maintenance Director would snake the toilet out and the toilets would then work fine.
-No one had told her water was backing up into the shower until the surveyor pointed it out.
-There had been an issue with the septic system for six months, and at the time of the interview, it

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D 105	Continued From page 24 was overflowing into the woods. Confidential interview with a staff member revealed every septic company that had been to the facility said the pumps needed to be repaired, and that pumping off the septic tanks was a temporary fix. Interview with the Administrator on 08/06/26 at 7:20am revealed: -The septic tank was pumped three times a year, in August 2025, December 2025, May 2026 and on July 8, 2026. -In May 2026, staff saw tissue on the ground in the back of the facility, and she called the septic company to have the system pumped. -At the end of June 2026, she was contacted by a representative at the local health department for a complaint about the septic system. -She was given 30 days to get the septic system fixed. -She called several septic companies to obtain estimates on repairing the septic system. -She was going to decide by Friday, 08/07/26, which company she was going to use to complete the work on the septic system. Interview with the Administrator on 08/07/26 at 3:24pm revealed when a resident's toilet was stopped up, even after hours, the toilet would be unclogged and back operational within no more than five hours. _____ The facility failed to ensure the septic system pumps were maintained in working order and the septic tanks were pumped as needed, which resulted in wastewater backing up into three bathrooms and the shower in the SCU used by the residents. The residents were exposed to unsanitary conditions and sewage, including	D 105		

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D 105	Continued From page 25 wastewater backing up onto residents' feet while showering, and limited residents' access to functioning bathroom facilities. The facility's failure placed the residents at substantial risk for physical harm which constitutes a Type A2 Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 08/06/26. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2026.	D 105		
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	D 259		

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D 259	Continued From page 26 this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (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 interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#4) had care plans that were signed and dated by the primary care provider (PCP) within 15 days of completion of the care plan. The findings are: Review of Resident #4's current FL2 dated 05/12/26 revealed diagnoses included diabetes mellitus type 2, bilaterial blindness, and hypertension. Review of Resident #4's Resident Register revealed an admission date of 04/12/26. Review of Resident #4's Care Plan dated 05/05/26 revealed it was not signed and dated by the PCP until 08/06/26.	D 259		

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D 259	Continued From page 27 Interview with the Resident Care Coordinator (RCC) on 08/06/26 at 10:57am revealed: -She was responsible for assessing the residents and completing the care plans. -She did not realize the PCP had not signed the care plan until today, 08/06/26. Interview with the Executive Director (ED) on 08/07/26 at 1:49pm revealed: -The RCC was responsible for completing care plans. -She expected the RCC to have the PCP sign the care plan within 15 days of the care plan being completed. Interview with the Administrator on 08/07/26 at 3:46pm revealed: -The RCC was responsible for completing care plans. -The care plan should have been signed by the PCP within 15 days of her completing the care plan. -She expected the RCC to have the care plan signed by the PCP within 15 days.	D 259		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by:	D 269		

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D 269	Continued From page 28 TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 2 of 5 sampled residents (#3 and #4) related to nail care. The findings are: Review of the facility's undated policy on Podiatry Services revealed: -Residents would receive podiatry services in accordance with an individual's needs and in compliance with Adult Care Home regulations. -The facility would coordinate routine maintenance or treatment to foot-related medical conditions. -Staff were responsible for ensuring timely scheduling of appointments. 1. Review of Resident #3's current FL2 dated 10/29/25 revealed diagnoses included dementia, hypertension, blindness in both eyes, depression and anxiety. Observation of Resident #3 on 08/05/26 at 8:53am revealed: -She was lying on her bed without shoes or socks. -Her toenails were various lengths, some extended past the tip of her toe and were jagged across the top. -Some of her toenails had grown over the top of her toe and were curved around the tip of the toe in various directions. -Her toenails were long, thick, curved, yellow, dark brown, and black and they had deep ridges in them. -There was debris around and under the toenails. -The skin around and between her toes was	D 269		

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yellowed, crusted, peeling and flaking.

Review of Resident #3's charting notes from March 2026 to July 2026 revealed there was no documentation regarding Resident #3's toenails, toenail care or contact with a podiatrist.

Review of Resident #3's skin assessment sheets from July 2026 to August 2026 revealed there was no documentation of Resident #3's feet or toenails.

Review of an email from the facility's contracted podiatrist dated 08/05/26 at 4:26pm revealed:
-The email sent to the facility and was signed by the podiatrist's lead Medical Technician.
-Resident #3 was not seen by the podiatrist on 02/27/26 or 05/05/26.
-Resident #3 was taken off the list to be seen by the podiatrist due to the family refusing the podiatrist to provide foot care.

Interview with Resident #3 on 08/07/26 at 8:35am revealed:
-She did not know the last time her toenails were cut.
-She could not see her toenails very well.
-She did not realize they needed cutting.
-She wore slip on shoes without socks because they were the only shoes she had.
-Her feet and toes did not hurt and did not bother her when she walked.
-She did not know if she was asked if she wanted her toenails cut.
-She would let the podiatrist cut her toenails.

Telephone interview with a representative from the facility's contracted podiatrist office on 08/06/26 at 11:25am revealed:
-Someone from the facility had called her that

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morning and gave her past dates for podiatry visits and asked if Resident #3 had been seen by the podiatrist on those dates.
-She could not see the date for the last time Resident #3 was seen by the podiatrist.
-She saw a note where the family took her off the list to be seen by the podiatrist and they did not want them providing care.
-There were no names of family on the note and no date.

Telephone interview with Resident #3's family member on 08/06/26 at 11:55am revealed:
-She saw Resident #3 six months ago and said something to staff about Resident #3's toenails being too long.
-She had never told the podiatrist's office not to see Resident #3 or to not provide care for her feet and toes.
-Another family member visited Resident #3 once a week because they lived closer.
-Resident #3 had a guardian.

Telephone interview with Resident #3's second family member on 08/06/26 at 4:20pm revealed:
-She visited Resident #3 once a week.
-She had complained to staff about Resident #3's toenails multiple times; she could not recall the last time she complained.
-She could not recall who she spoke to but she had not spoken to the Administrator; she thought it was a personal care aide (PCA).
-She had not denied for Resident #3 to be seen by a podiatrist; she was not aware of any of the rest of the family denying podiatry care because Resident #3 had a guardian.
-She wanted Resident #3 to be seen by a podiatrist.
-She complained because Resident #3's toenails were getting terrible and she was concerned

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about infection; one toenail looked like it was going to fall off.
-She saw Resident #3's toenails last week and thought they were getting worse.
-Resident #3 would not ask for her toenails to be cut and would not complain of pain.
-Resident #3 could not see well and might not be able to see her toenails and feet to see how bad they were.
-Resident #3 would initially refuse toenail care but would agree to it if someone talked to her; staff would ask her and then just walk away.

Telephone interview with a representative from Resident #3's guardian's office on 08/06/26 at 11:40am revealed:
-The facility sent a request for consent to the guardian for podiatry care for Resident #3 dated April 2025.
-He did not see where the consent form was signed or denied by the guardian.
-There were no other requests for consent for podiatry care in Resident #3's record.

Interview with Resident #3's primary care provider (PCP) on 08/06/26 at 11:55am revealed:
-She was not familiar with Resident #3's toenails and what they looked like.
-The facility had a podiatrist who provided toenail and foot care to the residents.
-She would look at a resident's toenails per request from the staff or the resident and then do a referral to the podiatrist.
-Resident #3 had not complained about her toenails or that she was in any pain; the resident could tell her if she was in pain.
-After seeing Resident #3's toenails, today, 08/06/26, they looked like there was a fungus and they needed cutting.
-She would write a referral for podiatry because

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they could cause pain.

Interview with the facility's contracted Nurse on 08/07/26 at 10:50am revealed:
-She visited the facility and cut residents' toenails if they requested her to cut them.
-The medication aide (MA) would come to her and ask her to cut a resident's toes.
-The PCAs did not ask her to cut toenails for residents.
-Resident #3 let her cut her toenails in the last year; Resident #3 walked by the room she was working in and asked her to cut her toenails.
-She could not recall the date when last cut Resident #3's toenails.
-She did not recall what Resident #3's toenails looked like when she cut them.
-After seeing Resident #3's feet today, she thought they looked bad; her nails were long and she had a fungus.
-Resident #3 was not a diabetic and did not have to be seen by the podiatrist.
-Because she was a Registered Nurse (RN), she did not need permission from family or guardians and could cut Resident #3's toenails without an order; she could also request the PCP look at her feet due to the fungus.
-Resident #3 could lose one or two of her toenails due to the fungus.
-Resident #3 would refuse care but could usually be redirected and be persuaded to allow the care be provided.
-She was scheduled the next Tuesday to cut residents' toenails and she would work with Resident #3 to convince her to cut her toenails.
-If the staff had told her Resident #3's feet and toenails looked that bad, she would have cut them by now.

Interview with a PCA on 08/07/26 at 3:25pm

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revealed:
-Resident #3 needed assistance with showering and did not refuse.
-She did a skin assessment when she gave Resident #3 a shower and documented it on the skin assessment sheet.
-She did not look at Resident #3's feet so she did not document anything on the skin assessment sheet.

Interview with a MA on 08/07/26 at 10:45am revealed:
-The PCAs did skin assessments when they gave residents a shower.
-The PCAs could put information about a resident's toenails and mark it on the skin assessment sheet.
-She reviewed the shower sheets or the PCAs would verbally tell her when a resident's toenails needed cut.
-When a PCA notified her a resident needed to have their toenails cut, she would notify the facility's Nurse and the Resident Care Coordinator (RCC).
-The PCAs had not told her about Resident #3's toenails or she would have told the facility's Nurse when she came.
-Resident #3 had not complained to her and she had not heard any complaints about the resident's toenails.
-Resident #3 refused a lot of care but she did not know if she refused to have her toenails to be cut.

Interview with the RCC on 08/07/26 at 10:10am revealed:
-All residents were seen by the podiatrist every six months.
-She did not inspect residents' toenails.
-The staff usually alerted her if anyone needed their toenails cut.

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D 269	Continued From page 34 -The PCAs gave the residents their showers and checked their skin but they did not check their feet. -She saw Resident #3's toenails on Monday or Tuesday of that week, and she did not think the toenails were too bad, just a bit of yellowish tint and needed to be cut. -She took a picture but did not know if anything was documented in Resident #3's chart notes. -Resident #3 had not complained of pain because of her toenails. -The family came often to visit Resident #3 but had not complained of her toenails. -She was going to reach out to the family to see if they could help the facility out and convince Resident #3 to get her toenails cut; possibly have them at the facility to help convince her. Interview with the Executive Director (ED) on 08/07/26 12:10pm revealed: -Resident #3 was on the list to be seen by the podiatrist on 05/05/26 but she refused. -The refusal was not documented anywhere. -The residents had the right to refuse care; including toenails and feet. -She had offered to cut Resident #3's toenails before, but the resident refused. -She was not aware Resident #3's toenails looked like they did until that week. -Resident #3's toenails definitely needed cutting. -The PCAs should have let the MA, the RCC or her know how Resident #3's toenails looked. -She had not heard of any complaints from Resident #3 or her family about her toenails. -If she did not know then she could not do anything about it. -The facility's RN did not need permission from the guardian or family to cut a resident's toenails. -She was going to have the facility Nurse look at Resident #3's toenails and attempt to cut them.	D 269		

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D 269	Continued From page 35 -Resident #3 refused care but she felt like the Nurse could work with Resident #3 and let her cut her toenails. Interview with the Administrator on 08/07/26 at 1:30pm revealed: -She knew in November of 2025 there was documentation Resident #3 refused to have her nails cut. -She did not know if it was the family or the guardian that refused the podiatry care. -Resident #3 refused care often and after she refused podiatry care a number of times, the podiatrist would notify the family. -No one had come to her and told her about the condition of Resident #3's feet and toenails. -Resident #3 had not complained about her feet to any of the staff. -The PCAs should have looked at Resident #3's toenails and feet during her showers and reported how they looked to her. -The PCAs washed Resident #3's feet when they gave her a shower three times a week. -The Licensed Health Professional Support (LHPS) nurse had not documented any concerns about Resident #3's toenails on her assessments. -She saw Resident #3's feet in June 2026 and she thought they looked good. -Resident #3 told the PCP she did not want her toenails cut when she saw her that week. -Resident #3 told the RCC and the facility Nurse today, 08/07/26, that she did not want her toenails cut. -If Resident #3 was in pain she would get the guardian involved to get Resident #3 to agree to getting her toenails cut; maybe even have the guardian on site when they cut her nails. -Resident #3 refused most of her care and seemed depressed since her recent cancer treatments.	D 269		

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D 269	Continued From page 36 Attempted telephone interview with Resident #3's guardian on 08/06/26 at 10:40am was unsuccessful. Attempted telephone interview with Resident #3's guardian's supervisor on 08/06/26 at 10:42am was unsuccessful. Attempted telephone interview with the facility's LHPS nurse on 08/07/26 at 11:46am was unsuccessful. 2. Review of Resident #4's FL2 dated 04/12/26 revealed: -Diagnoses included diabetes mellitus type 2, bilateral blindness, and hypertension. -He needed assistance with bathing. Review of Resident #4's care plan dated 05/05/26 revealed: -He required limited assistance from staff with eating and toileting. -He required extensive assistance from staff with ambulation, bathing, dressing, grooming, and transferring. Observation of Resident #4 on 08/06/26 at 10:48am revealed: -The skin on top of the resident's feet was dry and flaky. -There was a buildup of debris and dried skin under and between his toes on the bottom of his left and right foot. -Four of his toenails were discolored and thick. -The first toenail on his left foot extended past the end of his toe by ¾ inch. -The second toenail on his left foot extended past the end of his toe by ¼ inch and was curved toward the first toe.	D 269		

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-The first toenail on his right toe extended past the end of his toe by ½ inch and had deep ridges in the toenail.
-The second toenail on his right foot extended past the end of his toe by ¼ inch and was beginning to curve under.
-The third toenail on his right foot extended past the end of his toe by ½ inch.

Review of Resident #4's charting notes from May 2026 to August 6, 2026, revealed there was no documentation regarding Resident #4's toenails or contact with a podiatrist.

Review of Resident #4's skin assessments from May 2026 to August 2026, revealed there was no documentation of his toenails.

Interview with Resident #4 on 08/06/26 at 11:38am revealed:
-He had not asked anyone to cut his toenails.
-He had not refused to have his toenails cut.
-He did not know if he had told anyone his toenails needed to be cut.
-His toenails were not painful.

Interview with Resident #4's family member on 08/06/26 at 12:15pm revealed:
-The resident was admitted to the facility in May 2026 and had not had his toenails cut.
-She mentioned it to the medication aide (MA) a few months ago and was told staff would make sure his toenails were cut.
-She was concerned his toenails were not being cut because he was diabetic.

Interview with the facility's contracted primary care provider (PCP) on 08/06/26 at 11:51am revealed:
-She had not been notified that Resident #4

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needed to be seen by podiatry.
-If staff would have notified her, she would have made a referral for the resident to be seen by podiatry.
-She was concerned because the resident was at risk for a bacterial infection if he had cracked heels or scratched himself with his toenails.
-She expected the facility to notify her when Resident #4 needed to be seen by podiatry.

Telephone interview with the facility's contracted Registered Nurse (RN) on 08/07/26 at 11:13am revealed:
-She was not aware that Resident #4 needed his toenails cut.
-Staff should be looking at the resident's toenails during showers to determine when his toenails needed to be cut.
-The resident was at risk for infection if he scratched his legs with his toenails.
-The resident's toenails should be cut every three months.
-The resident should have been referred to podiatry.

Interview with a personal care aide (PCA) on 08/07/26 at 11:19am revealed:
-She did not document any concerns with Resident #4's toenails were as on his skin assessment on his shower days.
-She knew his toenails needed to be cut and reported it to the medication aide (MA) and Resident Care Coordinator (RCC) but could not remember when and was told the MA would take care of it.
-She helped Resident #4 with a shower last week and notified the RCC again about the resident's toenails.

Interview with another PCA on 08/07/26 at

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D 269	Continued From page 39 11:26am revealed: -She had not noticed Resident #4's toenails needed to be cut until recently. -She had not notified the MA or RCC. -The PCAs did not cut or file any resident's toenails or fingernails; they notified the MA or the RCC. Interview with a MA on 08/07/26 at 11:55am revealed: -She was not aware Resident #4 needed his toenails cut. -The PCAs were responsible for documenting any concerns with the toenails and if they needed to be cut on the skin assessment on shower days. -The MAs reviewed the skin assessments and notified the RCC when a resident needed to be seen by podiatry. -She had no other way of knowing there were issues with Resident #4's toenails was not documented on the skin assessment. -She was concerned that the resident was diabetic and could have cut himself with his toenails, causing an infection. Interview with the RCC on 08/07/26 at 11:35am revealed: -She did not know Resident #4 needed to be seen by podiatry. -She had not looked at Resident #4's toenails. -She was not aware that toenails should be documented on skin assessments. -She had not looked at Resident #4's skin assessments. Interview with the Executive Director (ED) on 08/07/26 at 1:49pm revealed: -The PCAs should complete skin assessments on residents on shower days and the condition of a resident's toenails should be documented.	D 269		

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(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 269	Continued From page 40 -The PCAs should report to the RCC when a resident needed their toenails cut. -The RCC should contact the PCP for a podiatry referral. Interview with an Administrator on 08/07/26 at 3:46pm revealed: -The PCAs should have documented any issues with Resident #4's toenails on the skin assessments on shower days. -The PCA should notify the RCC if a resident needed their toenails cut. -The RCC completed weekly skin assessment and should have noticed that Resident #4 needed to have his toenails cut. -The RCC should have notified the PCP, and the resident should have been referred to a podiatrist if his toenails needed to be cut. Attempted telephone interview with a representative from the facility's contracted podiatry services on 08/06/26 at 3:49pm was unsuccessful. _____ The facility failed to provide personal care for 2 of 5 sampled residents including a resident (#3) whose toenails were long, thick, discolored, and curved over the tip of her toe and had not been cut by anyone including facility staff, and a second resident (#4) with a history of diabetes and blindness whose toenails were long and putting him at risk of infection. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 08/07/26. THE CORRECTION DATE FOR THIS TYPE B	D 269		

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D 269	Continued From page 41 VIOLATION SHALL NOT EXCEED SEPTEMBER 21, 2026.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure referral and follow up to meet the health care needs of 1 of 5 sampled residents who had an order for an ultrasound (#2). The findings are: Review of Resident #2's FL2 dated 07/01/26 revealed: -Diagnoses included anemia, hypertension, congestive heart failure, excoriation disorder and history of deep vein thrombosis (DVT). -He was intermittently disoriented. Review of Resident #2's record revealed: -There was a procedure report dated 04/08/26 for a doppler ultrasound on Resident #2's leg. -Resident #2's left popliteal vein demonstrated a loss of volume when pressure was applied and absent color; which indicated there was a DVT involving the left popliteal vein. -The remaining veins demonstrated normal flow and volume when pressure was applied to the vein, and the femoral vein was open. -Eliquis (a medication used to thin the blood and	D 273		

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D 273	Continued From page 42 treat blood clots) was started on 04/08/26. Review of Resident #2's incident report dated 05/15/26 revealed: -Resident #2 had an emergency department (ED) visit for severe left leg pain and could barely stand up. -The after-care instructions from the ED visit on 05/15/26 instructed the resident to return for a deep vein ultrasound to evaluate for blood clots. -The ultrasound needed to be done in the cardiovascular lab. -Resident #2 should have the ultrasound completed within 24 hours or should return to the ED if unable to complete the ultrasound within 24 hours. -There was no documentation that an ultrasound was done within 24 hours or that the resident returned to the ED. Review of Resident #2's incident report dated 05/21/26 revealed Resident #4 was sent to the hospital for a scan of his left leg to be evaluated for a DVT. Review of the radiology report dated 05/21/26 revealed: -A new thrombus was identified by the venous duplex study. -The second thrombus identified was moderate in size in the left mid to distal femoral vein occupying 40% of the lumen. Interview with Resident #2 on 08/07/26 at 12:00pm revealed: -He knew he had a DVT. -He could not remember the date that he went to the ED or the date of his last ultrasound. -He only had pain when he started to walk first thing in the morning.	D 273		

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D 273	Continued From page 43 -He did not remember the name of his pain medication, but stated he gets pain medication, which helped. Interview with Resident #2's guardian on 08/06/26 at 11:33am revealed: -She was aware that Resident #2 had a DVT from the facility's notification on 05/21/26. -She did not know about the discharge follow-up instructions to return for an ultrasound within 24 hours or go to the ED. -She was not aware that a follow up ultrasound was needed. Interview with a medication aide (MA) on 08/07/26 at 11:16am revealed: -She was aware of Resident #2's severe left leg pain and swelling on 05/15/26. -The primary care provider (PCP) was notified and Resident #2 was sent to the ED on 05/15/26. -She was not aware of follow-up orders following the hospital encounter for an ultrasound within 24 hours or return to the ED. Telephone interview with the clinical supervisor from the local hospital's cardiovascular lab on 08/07/26 at 8:40am revealed: -Resident #2's discharge order written on 05/15/26 for an ultrasound should have been done as written within 24 hours or the resident should have returned to the ED. -There was not an appointment scheduled for an ultrasound within 24 hours following the ED encounter on 05/15/26. -An ultrasound was done in the outpatient cardiovascular lab on 05/21/26. -The resident was sent immediately to the ED from the cardiovascular lab on 05/21/26 because of a new moderate amount of thrombus in the left mid- to distal femoral vein.	D 273		

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D 273	Continued From page 44 -The cardiovascular notes indicated the concern of the new blood clot in Resident #2's leg and that the clot could break free and travel to the lungs and get stuck in the lung's artery (a pulmonary embolism). -This was a serious condition and could be life-threatening. Review of the aftercare instructions for Resident #2 from the ED on 05/21/26 revealed: -He should take the blood thinning medication prescribed to treat the DVT. -He should be on blood thinners for 3-6 months. -He should report any unusual bleeding immediately. -He should return to the nearest ED if his symptoms did not improve or got worse. Interview with Resident #2's PCP on 08/06/26 at 11:08am revealed she sent Resident #2 to the ED on 05/21/26 to obtain an ultrasound because the staff had informed her an ultrasound should have been done based on the discharge instructions dated 05/15/26. Interview with the Resident Care Coordinator (RCC) on 08/07/26 at 11:16am revealed: -She was not working in the facility in May 2026 and had no knowledge of what occurred with Resident #2's ultrasound order. -The follow up should have occurred within 24 hours or the resident should have been sent back to the ED. -The RCC was responsible for coordinating the ultrasound. Interview with the Administrator on 08/07/26 at 3:49pm revealed: -The discharge summary for Resident #2 was not read and therefore appropriate follow-up within 24	D 273		

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D 273	Continued From page 45 hours did not occur as ordered. -The discharge summary should have been read by the RCC. -A copy of the discharge summary should be given to the Administrator and Executive Director from the RCC. -A copy of the discharge summary should have been forwarded to the PCP by the RCC. _____ The facility failed to ensure health care follow up for Resident #2 who had an order for an ultrasound within 24 hours or return to the Emergency Department (ED). Resident #2 did not complete the ultrasound or return to the ED until 6 days later when a blood clot was identified. The delay in care for identifying and treating the blood clot was life-threatening and placed the resident at risk for a pulmonary embolism. This failure placed the resident at 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 08/07/26. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2026.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300	D 283		

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D 283	Continued From page 46	D 283		

which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure all food items stored and prepared by the facility were served under sanitary conditions related to dirty food storage containers that were not properly labeled and live roaches in the kitchen.

The findings are:

Review of the kitchen's environmental health inspection report conducted by the local department of health dated 04/24/26 revealed:
-The kitchen received a score of 97.5.
-There were no deductions for food storage containers, dating and labeling or live pests including roaches.

1. Observation of the kitchen on 08/05/26 at 8:09am revealed:
-There was a shelf under a prep table with bins on it.
-One had rice in it and the second bin had sugar in it.
-The bins were labeled but did not have dates on them.
-There was a brown and white buildup that was sticky to the touch on the outside and top of each bin.
-There was no cleaning schedule or cleaning list posted in the kitchen.

Interview with a dietary aide on 08/06/26 at 2:00pm revealed:
-Sometimes he put stock away when the food

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deliveries came.
-The sugar and the rice were stored in the tubs in the kitchen.
-He washed the inside and outside of the tubs when they were empty.
-The tubs did not fit in the sink so he took them to the sink and put detergent in them and washed them.
-He did not know to put a date on the sugar and rice bins.
-Every Tuesday and Thursday the kitchen staff deep cleaned in the kitchen and the tops of the bins would get washed off then.
-There was no cleaning schedule for the equipment in the kitchen.

Interview with a second dietary aide on 08/06/26 at 2:20pm revealed:
-He cleaned the sugar and rice bins a few months ago.
-The bins should be washed and cleaned every two weeks.
-There was not a cleaning schedule in the kitchen for them to follow.
-The staff cleaned the bins when they needed to be cleaned.

Interview with the Executive Director (ED) on 08/07/26 at 11:55am revealed:
-She and the Administrator oversaw the kitchen because the facility did not have a Kitchen Manager.
-She checked on the sanitation in the kitchen from time to time.
-She looked at labels and cleanliness of everything.
-She did not know where the storage bins in the kitchen came from or who brought them in.
-They were supposed to be deep cleaned on Mondays, Wednesdays, and Fridays.

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D 283	Continued From page 48 -She thought there was a cleaning list in the kitchen and the staff were supposed to check it to see what needed cleaning. -The staff were supposed to check the rice and sugar bins, remove the scoops, date and label and clean the bins if needed. Interview with the Administrator on 08/07/26 at 1:50pm revealed: -She and the ED were responsible for the kitchen. -The Kitchen Manager had retired a few months ago and they had not replaced her yet. -She did a weekly walk through of the kitchen and looked at the sanitation. -The sugar and rice bins were supposed to be cleaned when emptied and that was about every two to three weeks. -The lids to the bins were wiped cleaned weekly or as needed. -The bins were dated when the sugar and rice were put into them. -The kitchen staff should have cleaned the bins and dated them when they put new sugar and rice in them. 2. Observation of the kitchen on 08/06/26 at 3:05pm revealed: -There was a small live roach crawling on the wall of the kitchen next to the door that led to the dining room. -The roach crawled into a crack between the wall and the door frame. Observation of the kitchen on 08/06/26 at 3:25pm revealed there was a live roach crawling across the food preparation table and a live roach was crawling across the floor in the kitchen. Review of the facility's contracted pest control company's invoices for April 2026 to July 2026	D 283		

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revealed:
-The pest control company serviced the facility once a month.
-The pest control technician did a complete walk through of the building each visit and asked every available staff member about any pest issues they were aware of.
-There was a note on the invoice dated 06/25/26, the kitchen roaches at the reach in cooler and along the dish line wall were treated.
-There were no service notes on the other invoices.

Interview with a dietary aide on 08/07/26 at 8:50am revealed:
-He saw live bugs in the kitchen but he did not know if they were roaches because they were small.
-He saw large, dead roaches; he knew they were roaches because they looked like roaches.
-The pest control company sprayed for them.
-He saw one yesterday, 08/06/26, when a state surveyor was in the kitchen.
-Other kitchen staff said they had seen live roaches.
-He told the Administrator when he saw roaches.

Interview with a cook on 08/07/26 at 11:45am revealed:
-The roaches had gotten "outrageous" in the kitchen.
-She saw all different sizes of roaches in the kitchen.
-She did not see roaches every day in the kitchen.
-She saw a live roach that morning, 08/07/26, and a few minutes ago in the kitchen.
-The man from the pest control company sprayed but there were still roaches.
-The pest control man would ask her where she

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D 283	Continued From page 50 saw roaches. Interview with the Maintenance Director on 08/07/26 at 8:40am revealed: -He had seen dead roaches in the kitchen. -The staff reported to him that they saw live roaches in the kitchen about a week ago. -He reported the sightings to the Administrator. Interview with the Executive Director (ED) on 08/07/26 at 11:55am revealed: -She checked on the sanitation in the kitchen from time to time. -She looked for roaches but she did not see them. -Staff had reported seeing roaches in the kitchen but it had been over a month ago. -She called the pest control company and they came out and sprayed the kitchen and dining room. -The pest control company sprayed once a month but if they saw roaches or other bugs in the facility, he would come out twice a month. -The man that came from the pest control company and sprayed usually spoke to the staff or her when he came. -She thought the roaches in the kitchen had gotten better because she did not see them and there were no more reports of roaches from the kitchen staff. Interview with the Administrator on 08/07/26 at 1:50pm revealed: -She did a weekly walk through the kitchen and looked at the sanitation. -The pest control company treated for roaches by spraying the kitchen. -The kitchen staff did a deep cleaning once a month and the pest control company would spray after the deep cleaning.	D 283		

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D 283	Continued From page 51 -She knew there were roaches in the kitchen because staff had reported them and she had seen them too. -She had concerns about the number of live roaches that were seen in the kitchen; they had gotten better but there was still a lot of sightings. -She did not want the residents to see roaches while they were eating and become upset. -She decided on Tuesday, 08/04/26, she was going to get a pest control company that specialized in roaches to help get rid of the roaches. Attempted telephone interview with the facility's contracted pest control company on 08/07/26 at 4:01pm was unsuccessful. Attempted telephone interview with the inspector from the local department of health on 10:00am was unsuccessful.	D 283		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers.	D 286		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure residents who resided in the Special Care Unit (SCU) were provided with place settings including forks, knives, spoons, and a napkin at meals.

The findings are:

Review of the facility's current census on 08/05/26 revealed there were 9 residents residing in the Special Care Unit (SCU) and 32 residents residing in the Assisted Living (AL).

Observation of the lunch meal service in the SCU on 08/05/26 from 12:18pm-12:56pm revealed:
-There were nine residents in the dining room.
-All the residents were provided with a napkin and a spoon, three residents were provided with forks, and none of the residents were provided with knives.

Observations of the breakfast meal service in the SCU on 08/06/26 from 7:05am to 7:45am revealed:
-There was a food cart sent from the kitchen to the SCU.
-There were napkins and spoons on the cart; there were no forks or knives delivered to the SCU.
-There was only one personal care aide (PCA) in the dining room and she was feeding a resident.
-The residents' were given only a spoon at their place settings.
-The residents were served oatmeal, one waffle with syrup, a 3 inch round sausage patty, and canned sliced apples.
-Multiple residents were observed attempting to

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D 286	Continued From page 53 cut their waffles and sausage patties with the side of their spoons. -Multiple residents were attempting to pick up the waffles, apple slices and sausage patties with their spoons but were using their fingers to hold the food on the spoon or using their fingers to pick up the food and eat. -One resident was using a back and forth cutting motion with the side of her spoon in an attempt to cut her waffle; she gave up and used her fingers to pick up the waffle and eat it. -Another resident's waffle was torn into quarters and her sausage patty was torn into thirds. -A third resident was trying to pick up a piece of her waffle by stabbing it with her spoon. -The third resident scooped up the piece of waffle and held it onto the spoon with her fingers while she brought it to her mouth. -A fourth resident used the tip of his spoon to cut a slice of apple, the apple slice popped off his plate onto the table; he picked it up with his fingers and put it back on his plate and continued to attempt to cut the slice with his spoon. -The fourth resident was attempting to scoop the apple slices off his plate with his spoon and as he brought the spoon to his mouth the apple slice slid off the spoon and bounced onto the floor; he picked it up from the floor and put it on the table. -A fifth resident used her fingers to hold down her waffle and her sausage patty because they were moving back and forth while she used the side of her spoon to cut them. -A resident asked the PCA for a napkin, she went into the hallway and retrieved two napkins and gave one to the resident and used the second for the resident she was feeding. -A resident asked for seconds after his plate and spoon were removed; he was brought a large bowl of oatmeal and he was given a fork to eat it with.	D 286		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 286	Continued From page 54 -The resident leaned closely to the bowl of oatmeal and ate it with the fork. Observation of the kitchen on 08/06/26 at 3:00pm revealed: -There was an opened case of disposable napkins. -There were 50 knives, 41 forks, and 39 spoons available for resident use during meal service. -There were no other non-disposable utensils available for meal service. Interview with a PCA on 08/06/26 1:45pm revealed: -The kitchen staff sent a food cart to the SCU for each meal with forks, spoons and napkins on top. -She or the medication aide (MA) set the table with forks, spoons and napkins; the kitchen did not send knives for the residents to use. -Sometimes the kitchen staff only sent spoons for the residents in the SCU to use. -She did not know why the kitchen staff did not send knives for the SCU residents to use. -Residents did not ask for knives or forks at meals. -The residents used their spoons or forks to cut their food with. -She had not seen any residents struggling to cut their food. -She had not seen any of the residents struggling to pick up their food with their spoon when that was all they had to eat with. -Most of the residents picked up their food with their fingers to eat. -There had been times when there were no napkins on the food cart. -One of the residents asked for her for a napkin that morning, 08/06/26. -She had not set the tables so she did not know why there were no napkins on the table because	D 286		

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D 286	Continued From page 55 they were on the food cart. Interview with the MA on 08/06/26 at 3:10pm revealed: -The kitchen only sent napkins, forks and spoons to the SCU. -The kitchen sent enough spoons and a couple of forks but there were never enough forks. -The Administrator said the residents in the SCU could not get knives because one of the residents tried to stab another resident. -The resident who tried to stab another resident had not lived at the facility since January 2026. -None of the residents asked for a knife. -If a resident needed anything cut up, the SCU staff cut it for them. -She would see a resident trying to cut their food with a spoon or a fork and she would cut it up for them. -She used the spoon to hold the food down and the side of the fork to cut up food for the residents. -She had not seen any residents struggling to pick up food with their spoons; at some point all the residents used their fingers to eat. Interview with a dietary aide on 08/06/26 at 2:00pm revealed: -The dietary aides set up the food cart for the SCU. -They were putting enough napkins, forks, knives and spoons for each resident to have one. -He was never told to not send knives or forks to the SCU, he always sent them. -Yesterday, 08/05/26, at lunch they requested two forks from the SCU. -There were enough forks, knives and spoons in the kitchen to send one for each resident in the SCU.	D 286		

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D 286	Continued From page 56 Interview with a second dietary aide on 08/06/26 at 2:20pm revealed: -He set the food cart for the SCU today, 08/06/26 for breakfast and another dietary aide set it up for lunch. -He sent over a napkin, a fork, and a spoon for the residents in the SCU. -He was trained by another dietary aide and told not to send knives for the residents in the SCU because they did not need them. -He did not know where the forks from the food cart went if they were not on the cart at breakfast. Interview with the Special Care Unit Coordinator (SCC) on 08/07/26 2:50pm revealed: -The kitchen staff sent a fork, a knife, a spoon and a napkin for each resident on the food cart. -The PCAs preset the table including a fork, a knife, a spoon and a napkin at each place setting. -The residents in the SCU were monitored by the staff while they ate; if a resident needed their food cut up the staff would assist them. -At one time they did not send knives because of an incident between two residents, but they sent them now. -The residents would need a knife to cut their waffles and their sausage. -The residents definitely needed a fork at every meal and she was not aware the kitchen was not providing forks. -The PCA must have forgotten to put the napkins on the table but she should have given every resident a napkin after a resident asked for one. -She monitored one meal a day at different meals and the meal she observed had a fork, knife, spoon, and a napkin. -She was disappointed the PCAs did not call the kitchen and request forks and knives for the residents.	D 286		

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D 286	Continued From page 57 Interview with the Executive Director (ED) on 08/07/26 at 11:55am revealed: -The kitchen staff was supposed to send a napkin, a spoon, a knife, and a fork for each resident to the SCU. -The kitchen staff had never been told not to send a fork, and a knife to the residents in the SCU. -The PCA and the MA set the tables in the SCU and should make sure there was a napkin, a fork, a spoon and a knife at each place setting. Interview with the Administrator on 08/07/26 at 2:15pm revealed: -The residents in the SCU only got a fork and spoon with their meals. -There was a resident in the SCU that used a knife as a weapon so she took the knives from all the residents to be safe. -The resident moved out of the facility a few months ago and she forgot to give the knives back to the residents to use. -The kitchen had enough forks, knives, and spoons for all the residents in the facility and she could always order more. -She asked the dietary aide why he only sent the spoons to the SCU and he said he forgot to send the forks. -The PCA should have put the napkins on the tables when she set them and she should have given all the residents one when the one resident had to ask for one.	D 286		
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	D 296		

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D 296	Continued From page 58 therapeutic diet for guidance of food service staff.	D 296		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to have matching therapeutic diet menus for food service staff guidance for 2 of 6 sampled residents (#1, #7) who had a physician's order for a mechanical soft (MS) diet (#1) and a low concentrated sweets (LCS) diet (#6).

The findings are:

1. Review of Resident #1's current FL2 dated 07/14/26 revealed:
-Diagnoses included dementia, history of cerebrovascular accident and hypertension.
-Resident #1 resided in the Special Care Unit (SCU).
-There was a check mark next to diet but no therapeutic diets were documented.

Review of Resident #1's diet order dated 07/07/26 revealed:
-Resident #1 was ordered a mechanical soft (MS) chopped diet.
-The diet order identified a MS chopped diet as a diet for residents who had difficulty chewing but could tolerate more texture that a pureed diet offered.

Review of the facility's therapeutic diet menus for the week of 08/02/26 revealed there was no MS

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D 296	Continued From page 59 diet on the therapeutic menu. Observation of the breakfast meal in the SCU on 08/06/26 from 7:09am to 7:30am revealed: -Resident #1 was served a single round waffle torn into quarters, a three inch sausage patty that was torn into thirds, sliced canned apples and oatmeal. -Resident #1's waffle was not moistened with syrup. -Resident #1 was only given a spoon to eat with. -She attempted to cut the sausage and the waffle with the side of her spoon. -Resident #1 ate 100 percent of her waffle, canned apples and her oatmeal, and two thirds of her sausage. Telephone interview with Resident #1's primary care provider (PCP) on 08/07/26 at 4:55pm revealed: -MS foods were ordered for residents with chewing and swallowing issues. -A MS diet was all foods were soft, cut into smaller bites, moistened and easy to chew and swallow. Interview with a cook on 08/06/26 at 2:35pm revealed: -She did not follow a therapeutic diet menu. -She used the weekly menu and the referenced the recipes if she had a question. -She did not reference the therapeutic diet menu to prepare the MS meal because it was just chopped meat. -She prepared the MS chopped diet by placing the meat in the food processor and chopping it no wider than a fingernail. -Not every food item was chopped up unless it was hard. -Usually, vegetables and bread were not chopped	D 296		

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D 296	Continued From page 60 up unless there was an order. Interview with a second cook on 08/07/26 at 11:45am revealed: -There was a weekly menu and a recipe book in the kitchen for the cooks to use but there was no other menus. -She did not use a therapeutic diet menu when preparing meals and she did not recall if she saw one in the kitchen. -She knew how to prepare the food for a MS diet; it was soft meat chopped up like chicken in a chicken salad and soft vegetables. Interview with the Executive Director (ED) on 08/06/26 at 5:35pm revealed: -She and the Administrator oversaw the kitchen because the facility did not have a Kitchen Manager. -The cooks were supposed to follow the therapeutic diet menu when they prepared meal. -She thought the MS diet was on the therapeutic diet menu. -A MS diet was meats cut into small sizes so the residents could chew them. -The cooks were responsible for cutting the food for a MS diet but the staff in the dining room could cut a resident's meat if they needed something cut up. Interview with the Administrator on 08/06/26 at 5:38pm revealed: -The kitchen had a therapeutic diet menu for each diet that was on the diet sheet the PCP signed when ordering diets. -A MS diet was cut up meat and soft food. -The cooks were supposed to cut up the food in the kitchen. -The waffle and sausage should have been cut up in the kitchen.	D 296		

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D 296	Continued From page 61 2. Review of Resident #6's current FL2 dated 07/16/26 revealed: -Diagnoses included chronic kidney disease stage 3, and type 2 diabetes mellitus. -There was a check mark next to diet but no therapeutic diets were documented. Review of Resident #6's diet order dated 04/29/26 revealed: -Resident #6 was ordered a low concentrated sweets (LCS) diet. -The diet order identified a LCS diet as a diet with half of regular desserts and possibly a smaller amount of starch foods, depending on the rest of the meal. Review of the facility's therapeutic diet menus for the week of 08/02/26 revealed there was no LCS diet listed on the therapeutic menu. Observation of the lunch meal on 08/05/26 from 12:08pm to 12:25pm revealed: -Resident #6 was served ground chicken without gravy, pureed lima beans, pureed green beans, pudding, water, fruit punch and milk. -Resident #6 ate 100 percent of his meal. Observation of the lunch meal on 08/06/26 from 12:10pm to 12:21pm revealed: -Resident #6 was served a pureed pork chop, pureed mixed vegetables, pureed potato, water, fruit punch, and milk. -Resident #6 at less than 50 percent of his meal. Telephone interview with Resident #6's primary care provider (PCP) on 08/07/26 at 4:55pm revealed: -Resident #6 was a diabetic and he was ordered a LCS.	D 296		

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D 296	Continued From page 62 -She choose the diets to order from the therapeutic diets the facility offered. -Unfortunately, she did not think the diet orders were followed by the facility. Interview with a cook on 08/06/26 at 2:35pm revealed: -She did not follow a therapeutic diet menu. -She used the weekly menu and referenced the recipes if she had a question. -She did not know what a LCS diet was. -The diabetic residents were not served a therapeutic diet. Interview with a second cook on 08/07/26 at 11:45am revealed: -There was a weekly menu and a recipe book in the kitchen for the cooks to use but there was no other menus. -She did not use a therapeutic diet menu when preparing meals and she did not recall if she saw one in the kitchen. -She was not sure what a LCS diet was, she thought it might be a low salt diet. -There were no residents who were ordered a LCS diet. -The residents who were diabetic were not ordered any kind of [therapeutic] diets. Interview with the Resident Care Coordinator (RCC) on 08/07/26 at 10:10am revealed: -She printed off the resident diet list and posted it in the kitchen for the staff. -She knew there were residents who were ordered the LCS diet but she did not know specifically who. -She knew the LCS stood for low concentrated sweets diet and was ordered for residents who were diabetic. -She did not have anything to do with the	D 296		

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D 296	Continued From page 63 therapeutic menu. Interview with the Executive Director (ED) on 08/07/26 at 11:55am revealed: -She and the Administrator oversaw the kitchen because the facility did not have a Kitchen Manager. -The cooks were supposed to follow the therapeutic diet menu when they prepared meals. -She did not know what the LCS diet was. -She knew the cooks did not cook with sugar. -She did not know if there were any residents who were ordered a LCS diet. Interview with the Administrator on 08/07/26 at 2:15pm revealed: -The kitchen had a therapeutic diet menu for each diet that was on the diet sheet the PCP signed when ordering diets. -The LCS diet was a low carbohydrate sweets diet that was ordered for diabetic residents. -She thought the LCS was on the therapeutic diet menu.	D 296		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost.	D 299		

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D 299	Continued From page 64	D 299		

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent of dairy servings were served three times daily to the residents in the Special Care Unit (SCU).

The findings are:

Review of the facility's current census on 08/05/26 revealed there were 9 residents residing in the SCU.

Review of the week at a glance menu for the week of 08/02/26 revealed 8 ounces of 2% milk was to be served for breakfast, lunch and dinner.

Review of the U.S. Department of Agriculture Dietary Guidelines for Americans revealed:
-Adults aged 19-59 and 60+ should consume a minimum of the equivalent of 3 cups of a dairy item daily for a 1600-calorie diet.
-Recommendations for daily dairy servings included 1 cup (8 ounces) of whole milk, 2% milk, 1% milk, non-fat/skim milk, buttermilk, lactose free milk, evaporated milk, and fortified soy milk.
-Milk based dessert included in dairy servings were 1 cup of frozen yogurt, pudding, sherbet, ice cream and a dairy-based smoothie.
-Yogurt included in dairy servings was 1 cup of milk-based yogurt, soy yogurt and kefir.
-Cheese included in dairy servings was one and a half ounces of sliced or cubed hard or soft natural cheese or one-third of a cup of shredded hard or soft natural cheese, cottage cheese was a 2-cups serving, and ricotta cheese was a half a cup

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D 299	Continued From page 65	D 299		

serving.
-The dairy serving equivalent of processed American cheese was 2 one-ounce slices or 2 ounces.
-Cream cheese, sour cream, and cream were not included as a dairy equivalent due to their low calcium content.
-Plant based milks other than soy milk were not included in an equivalent in the dairy group even though they may contain calcium because their overall nutritional content was not similar enough to dairy milk and soy milk.

Observation of the lunch meal in the SCU on 08/05/26 from 12:18pm-12:45pm revealed:
-Each resident was served a glass of water.
-None of the residents were offered or served milk.
-There were 9 glasses of milk on top of the dietary cart.

Interview with a dietary aide on 08/06/26 at 2:00pm revealed:
-The dietary aides set up the food cart for the SCU.
-He always poured 8 ounces of milk into a cup for each resident in the SCU for every meal.
-He put the cups of milk on top of the food cart and the staff in the SCU were responsible for serving it to the residents.

Interview with a second dietary aide on 08/06/26 at 2:20pm revealed he poured milk for every resident in the SCU for every meal and put them on top of the food cart.

Interview with a personal care aide (PCA) on 08/06/26 at 1:45pm revealed:
-The kitchen sent a food cart to the SCU with cups of milk on the top for breakfast, lunch and

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D 299	Continued From page 66 dinner. -The PCAs and the medication aide (MA) served milk to all the residents in the SCU at each meal. -She asked the residents if they wanted milk, but not all of them wanted milk. -She did not notice the residents did not get milk at breakfast the day before, 08/05/26. -It may have been missed. -Sometimes she was the only staff in the dining room. Interview with the MA on 08/06/26 at 3:10pm revealed: -The kitchen sent milk on the food cart; it was already poured into cups. -She did not preset the milk in the SCU. -She offered the residents in the SCU milk and if they did not want it she did not give it to them. -Sometimes the residents in the SCU wanted milk and sometimes they did not. Interview with the Special Care Unit Coordinator (SCC) on 08/07/26 at 2:50pm revealed: -The residents in the SCU were served milk three times a day at meals. -The SCU staff knew they were supposed to serve the milk and not ask the residents if they wanted milk. -She was not aware the milk was not served to the residents at breakfast on 08/05/26. -She monitored the dining room once daily at different meals. Interview with the Executive Director (ED) on 08/07/26 at 11:55am revealed: -Milk was not supposed to be offered to the residents in the SCU. -Milk was supposed to be served at every meal in the SCU because they would probably drink it if it was sitting in front of them.	D 299		

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D 299	Continued From page 67 Interview with the Administrator on 08/07/26 at 2:15pm revealed: -Milk was supposed to served not offered in the SCU. -Milk was served at all three meals. -The SCU staff knew they were to serve the milk to all the residents and not offer it.	D 299		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 2 of 6 sampled residents (#1, 6) including a resident who was ordered a mechanical soft (MS) diet (#1), and a resident who was ordered a pureed diet and honey thickened liquids (#6). The findings are: 1. Review of Resident #6's current FL2 dated 07/16/26 revealed: -Diagnoses included chronic kidney disease stage 3, type 2 diabetes mellitus and hyperlipidemia.	D 310		

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D 310	Continued From page 68 -There was a check mark next to diet but no diets were documented. a. Review of Resident #6's signed physician's order dated 01/16/26 revealed there was an order for honey thickened liquids. Review of Resident #6's diet order dated 04/29/26 revealed there was an order for honey thickened liquids. Review of Resident #6's primary care provider's (PCP) electronic triage note dated 08/06/26 at 6:46pm revealed: -Resident #6 had been having choking episodes at mealtimes and the episodes had increased. -There was a confirmation of Resident #6's diet order including honey thickened liquids. -The staff were reminded to monitor Resident #6 during meals. Review of the recommendations from The Academy of Nutrition and Dietetics revealed: -A honey thick liquid was ordered to ensure safe swallowing for residents with dysphagia (swallowing difficulties). -The honey thick fluid [liquid] should resemble liquid honey and drip slowly in dollops or drops from a spoon. -A honey thick liquid was smooth with no lumps. Observation of the lunch meal on 08/05/26 from 12:08pm to 12:25pm revealed: -Resident #6 was served water, fruit punch and milk in 8 oz plastic tumblers. -There were visible clumps of white thickener in the center at the bottom of the water. -The water was thicker at the bottom and had a thin consistency on the top. -The fruit punch was not smooth and had the	D 310		

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appearance of tapioca with small beads of undissolved thickener.
-The milk was a thick pudding consistency at the bottom of the glass and a thin consistency at the top.
-Resident #6 used a spoon to scoop the pudding thick milk out of the bottom of the cup and ate it.
-Resident #6 drank less than 10 percent of his water and 75 percent of his fruit punch.

Observation of the lunch meal on 08/06/26 from 12:10pm to 12:21pm revealed:
-Resident #6 was served a cup of jello but the staff removed it after they were told he could not have the gelatin because it would become a thin liquid when eaten.
-Resident #6 was served water, fruit punch and milk in 8 oz plastic tumblers.
-There were visible clumps of white thickener in the center at the bottom of the water.
-The water was thicker at the bottom and was a thin consistency on the top.
-The milk was a thick pudding consistency at the bottom of the glass and a thin consistency at the top.
-The fruit punch was not smooth and had the appearance of tapioca with small beads of undissolved thickener.
-Resident #6 began to eat his meal and drink from the beverages.
-At 12:16pm, Resident #6 was drinking his milk, he coughed, choked and began to strangle while coughing.
-A personal care aide (PCA) told Resident #6 to slow down while drinking.
-Resident #6 pushed his wheelchair away from the table and continued to cough; his face turned red.
-The PCA asked Resident #6 if he was going to vomit and he shook his head no; he was

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coughing and was unable to answer verbally.
-Resident #6 was instructed by staff to drink his water while he was still coughing and strangling.
-At 12:20pm, the water and milk were still at a thin consistency on top of a thicker consistency and the thickener was still visible at the bottom of the water.
-The dietary aide (DA) came to the table and stirred the water.
-The water became slightly thicker but the visible thickener became more translucent and broke into smaller pieces but it did not dissolve completely.
-The water did not reach a honey thick consistency.
-The DA stirred the milk which was still a pudding thick consistency at the bottom of the cup and a thin consistency at the top.
-The milk blended together and became thicker as the DA stirred it but it became a pudding thick consistency.
-Resident #6 continued to cough and strangle until 12:21pm; he then requested to leave the dining room.

Observation of the kitchen on 08/06/26 at 12:27pm revealed:
-There was a box of instant food and liquid thickener packets on a shelf in the kitchen.
-The label on the thickener packet had for swallowing difficulties on it.
-The packets were for adding to beverages to obtain a honey thickened consistency.
-Each packet was a premeasured 0.11 ounce portion.
-The package included directions to add the contents of the packet to an empty and dry glass, then quickly add four ounces of desired liquid while briskly stirring with a fork until dissolved.
-Allow 5 to 10 minutes for the beverage to reach

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the desired thickness.
-The results of the thickness depended on the type and temperature of the liquid.

Telephone interview with Resident #6's PCP on 08/07/26 at 4:55pm revealed:
-Resident #6 was diagnosed with dysphagia in September 2021.
-Resident #6 aspirated about a year ago; he then had a swallow test done and was ordered the honey thick liquids.
-He had the triage note from 08/06/26 for increased episodes of coughing.
-The wrong consistency could be caused by not waiting for the liquid to thicken or not stirring until the fluid was at the correct consistency.
-If the beverage was too thin Resident #6 would not be able to control the liquid when swallowed.
-Resident #6 was at risk of coughing or aspiration if his liquid was not the correct consistency.

Interview with Resident #6 on 08/06/26 at 8:55am revealed:
-Sometimes he was served thickened liquids; he did not know why his beverages were thickened.
-He did not think he needed to be served thickened liquids.
-He had a swallow test three years ago and he was served thickened liquids after that.
-He did not cough or choke when he drank his beverages but he did cough and choke when he was eating and drinking at the same time.
-He was not always served thickened liquids at his meals; he was served thickened liquids yesterday, 08/05/26, and today, 08/06/26, but not the day before, 08/04/26.
-Sometimes he had to consume his milk and other beverages with a spoon but he preferred to drink his beverages.

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D 310	Continued From page 72 Interviews with a DA on 08/06/26 at 12:21pm and 2:11pm revealed: -He was taught in his orientation class how to prepare thickened liquids. -He was trained to pour the beverage into the cup, then add the thickener, then stir until he could see the beverage thicken and let it sit for about 5 minutes. -He placed the thickened beverages in the refrigerator about a half an hour before meal service. -He did not read the directions on the packets of thickener. -He knew the consistency of a honey thickened beverage was supposed to be thick and slide off the spoon slowly but he did not know it was supposed to look like liquid honey. -No one ever checked the beverages he thickened to make sure they were the correct consistency. -He prepared the thickened beverages for Resident #6's meals on 08/05/26 and 08/06/26. -He poured one package of thickener into each beverage and stirred until the thickener was dissolved. -He thought the thickener had dissolved when he prepared them. -He did not notice the thickener at the bottom of the water cup and that the water was thick on the bottom and thin on the top. -He did not notice the milk was only thick at the bottom of the cup and not the top. -Resident #6 did not choke because the liquids were too thin; Resident #6 just choked all the time. Interview with a second DA on 08/06/26 at 2:30pm revealed: -He was trained how to make thickened liquids by the previous kitchen manager.	D 310		

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D 310	Continued From page 73 -He was told to add the beverage to the cup then pour the entire contents of the thickener packet into the cup and stir for a while until the thickener dissolved. -He could look into the cup and see if the thickener was dissolved in the water but he could not see if it was dissolved in the milk so he scraped the sides and bottom of the cup. -If it was done right then the beverage looked thicker; water and fruit punch would be cloudy. Interview with a cook on 08/06/26 at 2:45pm revealed: -She was trained to pour a half a packet of thickener into a small 6 oz cup and a whole packet into a large 8 oz cup. -She poured the beverage in the cup first and then the thickener and stirred. -It only took a few seconds to mix the thickener into the beverage; the beverage got thicker on its own. -She had not seen Resident #6 cough or choke while drinking or eating in the dining room. -She had seen him cough when he drank a soda from the vending machine. Interviews with a PCA on 08/06/26 at 12:20pm and 3:25pm revealed: -She knew Resident #6 strangled on the milk today because she could see it in his mouth as he was choking. -She thought Resident #6 was going to vomit when he began to strangle, that was why she asked him if he thought he was going to throw up. -Sometimes he coughed while he ate and drank but it had been months since he had an episode like today, 08/06/26. Interview with a medication aide (MA) on 08/06/26 at 5:00pm revealed:	D 310		

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D 310	Continued From page 74 -She checked the dining room before meals to make sure Resident #6's beverages were thickened. -She thought the cooks thickened the beverages. -If Resident #6's beverages were not thickened then she would thicken them. -She would pour the thickener from the packet into the beverage, stir and wait a minute or two before serving so it would get thick. -The directions for the thickener were on the back of the packet and instructed one packet to 6 ounces of fluid. -She checked Resident #6's beverages yesterday, 08/05/26 and today, 08/06/26 and she thought they were the correct consistency. -She moved the beverage around in the cup to see if it was the right consistency; not too thick and not too thin. -She had observed Resident #6 coughing after breakfast as he was leaving the dining room on Monday, 08/04/26. -He told her he was okay when she asked. Interview with the Resident Care Coordinator (RCC) on 08/06/26 at 4:25pm revealed: -The MA was responsible for making sure the residents' beverages were thickened. -She went into the dining room to make sure Resident #6's beverages were thickened. -The MAs would thicken the beverage if no one else did. -The packet of thickener was added to a premeasured amount of fluid. -The consistency of the beverage could not be too thick or too thin after it was thickened because the resident could get choked if it was too thin or too watery. Interview with the Executive Director (ED) on 08/06/26 at 5:20pm revealed:	D 310		

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D 310	Continued From page 75 -Resident #6 had an order for a honey thickened beverages. -The MA or the DA thickened Resident #6's beverages. -The kitchen had individual packets of thickener. -The entire packet of thickener was poured into the beverage and stirred for 10 minutes; the beverage thickened over time. -The beverage was served as soon as it got thick. -The beverage was thickened before Resident #6 came to the dining room. -She and the Administrator had conducted a training on how to thicken liquids. -The honey thick consistency was thick like a milkshake so Resident #6 would not choke. -Resident #6 had choked and aspirated in the past with thin consistency beverages. Interview with the Administrator on 08/06/26 at 5:38pm revealed: -The MA prepared the thickened liquids for meals. -The MAs poured the thickener into the cup with the beverage and stirred until it reached the correct consistency. -The DA, the MA and the PCAs monitored the residents during meals. -If the consistency of the thickened beverage was not correct, the resident could choke. -The smallest variation in the consistency of Resident #6's beverage caused him to choke. -Resident #6 had an order for a thickened liquid; the appearance should be like syrup. -Resident #6 was coughing during a meal about a week or two ago. -No one had reported Resident #6 recently coughing, choking or strangling at meals. b. Review of Resident #6's signed physician's order dated 01/16/26 revealed there was a diet	D 310		

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order for a pureed diet.

Review of Resident #6's electronic triage note from the PCP's office dated 04/16/26 revealed:
-The reason for the visit was for a diet order update and clarification.
-The electronic note was physically signed by Resident #6 PCP on 04/20/26.
-There was an order to continue current diet orders for a pureed diet.

Review of Resident #6's care plan dated 06/18/26 revealed he was ordered a pureed diet.

Review of the facility's therapeutic diet menu for 08/05/26 revealed:
-For the lunch meal the pureed diet was listed as pureed baked chicken, pureed broccoli florets, soaked cornbread and pudding.
-The green beans and lima beans were not on the weekly menu or the pureed therapeutic diet menu.

Review of the facility's therapeutic diet menu for 08/06/26 revealed:
-For the lunch meal the pureed diet was listed as pureed pork loin, pureed polenta, pureed glazed baby carrots and a soaked dinner roll.
-The mixed vegetables and potato salad were not on the weekly menu or the pureed therapeutic diet menu.

Observation of the lunch meal on 08/05/26 from 12:08pm to 12:25pm revealed:
-Resident #6 was served ground chicken without gravy, pureed lima beans, pureed green beans and pudding.
-Resident #6 coughed three times while he was eating.
-The PCA told Resident #6 to drink some fluids

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D 310	Continued From page 77 after he chewed. Observation of the lunch meal on 08/06/26 from 12:10pm to 12:21pm revealed: -Resident #6 was served a pureed pork chop that was not a smooth consistency but was sticky and lumpy. - He was served pureed mixed vegetables that did not have a smooth and uniform consistency, and pureed potato salad that had visible white chunks of potatoes in it and was not a smooth and uniform consistency. Observation of the kitchen on 08/06/26 at 3:04pm revealed: -There was a small electric food chopper on the counter in the kitchen. -The box for the food chopper was on a shelf above the counter. -The food chopper was a one and a half cup capacity residential grade chopper. -There was no commercial blender or food processor in the kitchen. Review of the recommendations from The Academy of Nutrition and Dietetics revealed: -The correct consistency for a pureed diet was a smooth, uniform and lump-free texture. -The pureed foods did not need to be chewed or bitten. -The pureed food should be moist and thick enough to hold its shape but not spread or run on the plate and have no thin liquid separating from it. -The pureed food must not be sticky or adhesive in the mouth. Review of recommendations of equipment guidelines for the International Dysphagia Diet Standardization Initiative (IDDSI) revealed the	D 310		

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recommendations for pureed foods included blixers (a commercial food preparation machine that combined the features of a food processor and a blender to obtain a pureed texture from solid foods), and commercial immersion blenders.

Telephone interview with Resident #6's PCP on 08/07/26 at 4:55pm revealed:
-Resident #6 was diagnosed with dysphagia in September 2021.
-Resident #6 aspirated about a year ago; he then had a swallow test done and was ordered the pureed diet.
-If Resident #6's puree was not correct, he could choke when eating and be at risk for aspiration.
-Pureed food should be smooth like baby food.

Interview with Resident #6 on 08/06/26 at 8:55am revealed:
-He was served pureed food at all of his meals.
-He did not know why he was served pureed food.
-He coughed and choked when he ate but did not know why.
-He coughed or choked almost every day at most of his meals.

Interview with a cook on 08/06/26 at 2:35pm revealed:
-She used the food processor in the kitchen to puree food.
-The day before, 08/05/26, she cut up the chicken and put it in the food processor alone and chopped it to finger size and then added broth and blended it again.
-If the chicken was too watery, she added thickener to it.
-She did not know how to describe how pureed food should look; she would not describe pureed

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food as baby food or mashed potato consistency.
-Pureed food was supposed to be like liquid but not flow like water on the plate.
-If the pureed food was too runny, it was the wrong consistency.
-If the pureed food slid and dripped off the spoon when it was turned on its side, it was the correct consistency for a pureed diet.
-She did not use a therapeutic diet menu for reference when preparing the pureed meal.
-Sometimes the MA checked the consistency of the food before a meal.
-She had not seen Resident #6 cough or choke while drinking or eating in the dining room.

Interviews with a PCA on 08/06/26 at 12:20pm and 3:25pm revealed:
-She had to stand near Resident #6 while he ate to make sure he did not choke.
-She had to tell Resident #6 to slow down while he was eating because he ate too fast.
-The last time he strangled because he was drinking while he had food in his mouth.
-Resident #6 had vomited while eating before because he rushed when he ate; the last time was two or three months ago.
-She told Resident #6 to slow down while he was eating today, 08/06/26, because he was eating too fast.
-Sometimes he coughed while he ate.

Interview with a MA on 08/06/26 at 5:00pm revealed:
-Resident #6 was on a pureed diet.
-She checked the consistency at every meal.
-The puree could not be too soupy; it had to be more like loose mashed potatoes or pudding.
-She had not had an issue with the consistency for the pureed diets.

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D 310	Continued From page 80 Interview with the RCC on 08/06/26 at 4:25pm revealed: -She monitored the dining room for pureed diet consistency at least once a week. -The puree consistency was supposed to be blended in a blender and look like baby food; it was not supposed to be a chopped consistency. Interview with the ED on 08/06/26 at 5:20pm revealed: -Resident #6 had an order for a pureed diet. -A pureed diet was where food was made with a thickener after it was pureed down. -Pureed food looked like baby food. Interview with the Administrator on 08/06/26 at 5:38pm revealed: -Resident #6 was ordered a pureed diet. -The cooks followed the guidance in the kitchen for the correct texture and consistency. -The cooks were using a food chopper to prepare the pureed food because the blixer she ordered broke after a few uses and had to be returned to the manufacturer. -She was waiting for the supplier to send her a new blixer or repair the broken one. -She purchased the food chopper about a month ago when the blixer broke. -The MAs and the RCC checked the pureed food at meals. -The pureed food was supposed to be like mashed potatoes. -The smallest variation in the consistency could cause a resident to choke. Refer to the interview with the Administrator on 08/06/26 at 5:38pm. _____ Interview with a medication aide (MA) on 08/06/26 at 5:00pm revealed:	D 310		

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D 310	Continued From page 81 -There was a PCA near Resident #6 in the dining room during meals so they could monitor Resident #6 while he ate. -Resident #6's problem was not eating or drinking too fast. -Any little thing strangled Resident #6; he seemed to be having increased problems with swallowing or the beverages were not thick enough. -Resident #6 coughed while eating but he did not cough every day or at every meal. -He would just clear his throat while eating and drinking. -She had seen him start to cough and then continue to cough like he had a tickle in the back of his throat. -Resident #6 did not vomit in the dining room or after eating that she was aware of. -There was a PCA in the back of the dining room during meals so the PCA could monitor Resident #6 and keep an eye on him. -Most of the time the PCA would tell her when he had a coughing spell. -She would report a coughing spell to the Resident Care Coordinator (RCC). Interview with the RCC on 08/06/26 at 4:25pm revealed: -The PCAs monitored the dining room during meal services. -The MA was in the dining room for each meal. -If a PCA observed Resident #6 coughing or choking then they would report it to her or the MA and the MA would report it to her. -There had been no reports of Resident #6 coughing or clearing his throat during meals. -She expected to be told if Resident #6 was coughing or choking in the dining room. Interview with the ED on 08/06/26 at 5:20pm revealed:	D 310		

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D 310	Continued From page 82 -Resident #6 had a history of aspiration and choking on his food if it was not the right texture. -The PCAs and the MAs monitored Resident #6 while he was in the dining room. -He normally coughed while eating and it did not need to be reported to her. -If Resident #6 strangled then it needed to be reported to her immediately. -She would remove Resident #6 from the dining room until he was better or call for emergency medical services (EMS) if he got worse. -She would call EMS if Resident #6 had an uncontrollable cough. -She had not had to call EMS for Resident #6 in a year. -No one reported to her that Resident #6 strangled in the dining room at lunch today, 08/06/26. Refer to the interview with the Administrator on 08/06/26 at 5:38pm. 2. Review of Resident #1's current FL2 dated 07/14/26 revealed: -Diagnoses included dementia, history of cerebrovascular accident and hypertension. -Resident #1 resided in the Special Care Unit (SCU). -There was a check mark next to diet but no diets were documented. Review of Resident #1's diet order dated 07/07/26 revealed: -Resident #1 was ordered a mechanical soft chopped diet. -The diet order identified a mechanical soft chopped diet as a diet for residents who had difficulty chewing but could tolerate more texture that a pureed diet offered.	D 310		

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D 310	Continued From page 83 Review of Resident #1's physician's orders dated 07/09/26 revealed an order for a mechanical soft (MA) chopped diet. Observation of the lunch meal in the SCU on 08/05/26 from 12:18pm-12:45pm revealed: -Resident #1 was served chicken cut into bite-sized pieces, two vegetables, pudding, and a slice of bread. -The personal care aide (PCA) removed Resident #1's plate from the table and returned it to the food cart. -The PCA stated the resident had been served the wrong plate. -The second plate served to Resident #1 had ground chicken without any gravy or sauce, two vegetables, pudding, and a slice of bread. -Resident #1 ate 100% of the bread, one vegetable, and the pudding. -She did not eat one of the vegetables or the chicken. Observation of the breakfast meal in the SCU on 08/06/26 from 7:09am to 7:30am revealed: -Resident #1 was served a single round waffle torn into quarters, a three inch sausage patty that was torn into thirds, sliced canned apples and oatmeal. -Resident #1's waffle was not moistened with syrup. -Resident #1 was only given a spoon to eat with. -She attempted to cut the sausage and the waffle with the side of her spoon. -Resident #1 ate 100% of her waffle, canned apples and her oatmeal, and two thirds of her sausage. Observation of the kitchen on 08/06/26 at 3:04pm revealed: -There was a small electric food chopper on the	D 310		

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counter in the kitchen.
-The box for the food chopper was on a shelf above the counter.
-The food chopper was a one and a half cup capacity residential grade chopper.
-There was no commercial blender or food processor in the kitchen.

Review of the recommendations from The Academy of Nutrition and Dietetics revealed:
-Residents were typically ordered a MS diet due to difficulty with chewing, dysphagia (difficulty swallowing), poor fitting dentures or digestive issues.
-The foods for a MS diet should be soft and bite sized.
-The foods pieces must be no larger than 1.5cm by 1.5 cm to reduce airway obstruction risk.
-Foods for a MS diet must be easily mashed with a fork and break apart und the pressure of a fork.
-Food items for a MS diet must be cooked until tender, moist and served with a gravy, sauce or extra broth to ease swallowing and reduce the need for excessive chewing.

Telephone interview with Resident #1's primary care provider (PCP) on 08/07/26 at 4:55pm revealed:
-MS foods were ordered for residents with chewing and swallowing issues.
-A MS diet meant all foods were soft, cut into smaller bites, moistened and easy to chew and swallow.

Interview with a cook on 08/06/26 at 2:45pm revealed:
-She did not use the therapeutic diet menu when preparing the MS chopped diet for residents.
-She was trained by another cook on how to prepare a MS diet.

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-She prepared the MS chopped diet by placing meat in the food processor and chopping it no wider than a fingernail.
-Not every food item was chopped up unless it was hard.
-Usually, vegetables and bread were not chopped up unless there was an order.

Interview with a medication aide (MA) on 08/06/26 at 3:10pm revealed:
-The kitchen staff cut the meat for Resident #1 in the kitchen before it came to the SCU.
-If a resident needed their meat or other food cut, she would do it for them.
-Resident #1 ate slowly but she ate well and ate without any problems.

Interview with the Special Care Unit Coordinator (SCC) on 08/07/26 at 2:55pm revealed:
-The cook was responsible for cutting the MS food before it came to the SCU.
-Resident #1's meat was cut up for her; she could chew her food and cut her own food or staff could cut it in the dining room.
-If the food was not cut up enough, Resident #1 could have trouble chewing and swallowing.

Interview with the Executive Director (ED) on 08/06/26 at 5:35pm revealed:
-A MS diet was meats cut into small sizes so the residents could chew them.
-The cooks were responsible for cutting the food for a MS diet but the staff in the dining room could cut a resident's meat if they needed something cut up.

Interview with the Administrator on 08/06/26 at 5:38pm revealed:
-A MS diet was cut up meat and soft food.
-The cooks were supposed to cut up the food in

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D 310	Continued From page 86 the kitchen. -The waffle and sausage should have been cut up in the kitchen. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. Refer to the interview with the Administrator on 08/06/26 at 5:38pm. _____ Interview with the Administrator on 08/06/26 at 5:38pm revealed: -She monitored meals three times a week. -The facility did not have a Kitchen Manager; she and the Executive Director monitored the kitchen and the meals. _____ The facility failed to ensure therapeutic diets were served as ordered for a resident who had a history of aspirating and difficulty with swallowing and was ordered a pureed diet but was served pureed foods at the incorrect consistency and coughed while eating them and had an order for honey thickened liquids but was served the incorrect consistency resulting in his beverages being too thin and causing him to strangle while drinking them. The facility's failure resulted in subtantial risk for physical harm, which constitutes a Type A2 Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 08/06/26. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2026.	D 310		

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D 312	Continued From page 87	D 312		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 1 sampled residents (#7) who required assistance with meals was assisted upon receipt of meals in a manner that was unhurried and preserved dignity and respect. The findings are: Review of Resident #7's current FL2 dated 01/28/26 revealed diagnoses included dementia, hypertension, esophageal reflux and glaucoma and resided in the Special Care Unit (SCU). Observation of the lunch meal service in the SCU on 08/05/26 from 12:18pm-12:56pm revealed: -There were nine residents in the dining room. -All of the residents were served their plates by the personal care aide (PCA). -At 12:31pm, the PCA squatted beside Resident #7, picked up Resident #7's spoon, and began to feed her. -At 12:32pm, the PCA stood up and continued to feed Resident #7. -The PCA leaned over Resident #7 to pick up her beverage cup and then gave her a swallow of the beverage.	D 312		

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D 312	Continued From page 88 -At 12:35pm, the PCA continued to stand while feeding Resident #7. -At 12:36pm, the PCA squatted beside Resident #7 and continued to feed her. -At 12:39pm, the PCA held Resident #7's spoon while standing back from Resident #7 and looking around the dining room, then gave her another bite of food. -At 12:40pm, the PCA gave Resident #7 a swallow of her beverage while standing beside her. -Resident #7 ate 95% of her meal. Observations of the breakfast meal service in the SCU on 08/06/26 from 7:05am to 7:45am revealed: -There was only one PCA and no other staff in the dining room with nine residents. -The PCA held a plate in one hand as she stood to feed Resident #7. -She was queuing and attending to other residents while she fed Resident #7. -She left the dining room to retrieve items from the food cart in the hallway for another resident. -Resident #7 ate 100% of her meal. Interview with a PCA on 08/06/26 1:45pm revealed: -Resident #7 did not eat on her own so she had to be fed her meals. -Resident #7 could drink a beverage on her own but she needed to have the cup handed to her. -She was the only staff in the dining room during meals most days. -The medication aide (MA) would come in and help her if she finished administering medication before the meal was over. -The Special Care Unit Coordinator (SCC) trained her on how to provide feeding assistance. -She was trained to not put too much food on the	D 312		

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spoon and to monitor Resident #7 while she ate because she pocketed her food.
-She had not been given any additional instructions or guidelines for feeding residents.
-She did not know she should sit while feeding Resident #7.
-There was nowhere for her to sit while feeding Resident #7 and she was always assisting other residents if they needed something; even while she was feeding Resident #7.

Interview with the MA on 08/06/26 at 3:10pm revealed:
-She did not train staff on how to feed residents.
-She was trained to sit next to the resident and feed them one at a time.
-She had seen PCAs standing while they fed residents; she would tell them to sit.
-She helped in the dining room during meals after she administered medications and when she could.

Interview with the SCC on 08/07/26 at 2:50pm revealed:
-The PCAs were trained on how to feed residents during their orientation.
-The PCAs then shadowed another PCA.
-The proper way to feed a resident was to sit beside the resident and only feed that resident.
-Sitting while feeding a resident provided the resident with dignity.
-The resident should not feel rushed.
-She monitored the dining room once daily at different meals.
-She had not observed the PCA standing while feeding Resident #7.

Interview with the Executive Director (ED) on 08/07/26 at 12:10pm revealed:
-The PCAs were trained on feeding technique

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D 312	Continued From page 90 from a video during their orientation. -She had not observed Resident #7 being fed in the SCU. -The PCAs were supposed to sit while feeding residents so the resident does not feel rushed. -The PCAs were supposed to sit when feeding residents because it was also a dignity and respect issue. -No one wanted someone to stand over them while they ate. Interview with the Administrator on 08/07/26 at 1:50pm revealed: -The PCAs were trained at orientation on how to feed residents. -The PCAs were not allowed to stand while feeding a resident. -The reason for sitting with the resident was to give them time to eat and one on one attention. Based on observations, record reviews and interviews it was determined Resident #7 was not interviewable.	D 312		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure residents were treated with respect, consideration, and dignity when residents were required to use	D 338		

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another resident's bathroom in the assisted living (AL) and when residents in the special care unit (SCU) were required to use toilets that were clogged and not functioning properly.

The findings are:

Interview with a resident on 08/05/26 at 8:23am revealed:
-The toilet that connected room #27 and room #26 did not work.
-The water was turned off to the toilet and sink.
-The toilet would overflow if it was flushed when the water was turned on.
-She had been going across the hall to use the toilet in resident room #11.
-The bathroom in resident room #11 was smaller and she could not get her rollator walker in the smaller bathroom.
-She would leave her rollator at the door and hold onto the door and wall to use the toilet.
-She could wash up in the shower room down the hall.
-She could use the toilet down the hall.
-She cried as she told how someone walked in on her while she was using the toilet down the hall.
-It bothered her to go across the hall and use the toilet in room #11.
-She did not complain to the staff about the toilet because she didn't want staff to get mad at her.
-The toilet had been broken for 5 days.

Interview with a resident on 08/05/26 at 8:30am revealed:
-She had been going across the hall to use the toilet in resident room #11.
-The bathroom in resident room #11 was smaller and she could not get her wheelchair in the smaller bathroom.
-She would leave her wheelchair outside of the

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bathroom and hold onto the door and wall to use the toilet.
-The toilet had been broken for 5 to 7 days.

Interview with another resident on 08/06/26 at 7:45am revealed:
-She moved into the facility on 08/05/26.
-The staff told her to use the bathroom in the residents' room across the hall.
-They told her the bathroom in her room was broken.
-They did not say how long she would have to use the bathroom across the hall.
-She did not wake up to use the bathroom in the middle of the night yet.
-She did not know if she could use the sink in her bathroom.

Interview with a personal care aide (PCA) on 08/06/26 at 10:00am revealed:
-The toilets did not work when she returned to work on Monday 08/03/26.
-The residents were told to use the bathroom down the hall or use the bathroom in resident room #11.

Interview with the Resident Care Coordinator (RCC) on 08/07/26 at 10:15 am revealed:
-She was aware of the toilet not working and the Maintenance Director was working to resolve the issue.
-The residents were instructed to use the hall bathroom down the hall from their room.

Observation of the bathroom in resident room #4 in the SCU revealed:
-On 08/05/25 at 8:34am, the toilet was full of water to the rim.
-The toilet contained a small amount of toilet paper.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 338	Continued From page 93 -On 08/05/26 at 2:42pm, the floor around the base of the toilet was wet. -The toilet was full of used toilet paper, including feces. -On 08/06/26 at 2:39pm, a resident was using the toilet. -On 08/06/26 at 2:46pm, the toilet had a small amount of water at the bottom and contained several wads of used toilet paper. -On 08/07/26 at 8:25am, there was a small amount of water at the bottom of the toilet, a blanket on the floor surrounding the base of the toilet, and the blanket was wet. Based on observations and interviews, the resident who resided in this room was not interviewable. Observation of the bathroom in room #6 in the SCU on 08/05/26 revealed: -On 08/05/26 at 8:37am, the toilet overflowed onto the floor. -On 08/06/26 at 7:11am, the toilet had a small amount of water and one wad of toilet paper; there was a pile of wet blankets and towels on the floor. -On 08/06/26 at 5:06pm, there were blankets on the floor surrounding the base of the toilet; the blankets were wet. -On 08/07/26 at 10:07am, there were blankets on the floor surrounding the base of the toilet; one of the blankets was soaking wet. Interview with one of the residents who resided in resident room #6 in the SCU on 08/06/26 at 4:59pm revealed: -The toilet had been stopped up for "a bit." -She had to go down the hall to use another bathroom. -She was uncomfortable having to use the	D 338		

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D 338	Continued From page 94 bathroom down the hall. Interview with the second resident who resided in resident room #6 in the SCU on 08/06/26 at 5:03pm revealed: -The toilet was constantly stopped up, and there was water on the floor. -It had been going on for a while. -She felt like she was being neglected. -She had not told anybody about the toilet because they were not going to do anything about it anyway. Interview with the SCU Coordinator (SCC) on 08/07/26 at 9:41am revealed there had been problems with the two residents' toilets in the SCU before, but usually the housekeeper and/or Maintenance Director would snake the toilet out and the toilets would then work fine. Interview with a medication aide (MA) on 08/07/26 at 10:11am revealed the two residents' toilets were stopped up all the time, but she thought it was because the residents used too much paper. Interview with the Administrator on 08/07/26 at 3:24pm revealed when a resident's toilet was stopped up, even after hours, the toilet would be unclogged and back operational within no more than five hours. _____ The facility failed to ensure residents' rights were maintained and that residents were treated with dignity and respect when residents were required to use toilets that were repeatedly clogged and overflowing. Residents were also required to use bathrooms down other halls, not close to their rooms, which created a safety hazard for one resident who could not fit her rollator walker in the	D 338		

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D 338	Continued From page 95 smaller bathroom, and a second resident was unable to use a different bathroom because her wheelchair would not fit inside the smaller bathroom she was told to use. These residents had to leave their assistive devices outside of the bathroom and use the wall to ambulate to the toilet which was unsafe for the residents. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 08/07/26. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 21, 2026.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	D 344		

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D 344	Continued From page 96 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify orders for 1 of 5 sampled residents (#5), including a medication used to treat diabetes, an eye drop, a cream, and orders to check finger stick blood sugar (FSBS) readings and blood pressure (BP). The findings are: Review of Resident #5's current FL2 dated 07/31/26 revealed diagnoses included chronic kidney disease, type 2 diabetes, gastro-esophageal reflux disease (GERD), dementia, and hypertension. a. Review of Resident #5's current FL2 dated 07/31/26 revealed there was an order for Lantus Solostar (used to help manage blood sugar levels) 100 units/mL, 12 units; there was no documentation of the frequency. Review of Resident #5's physician's orders and facility progress notes revealed no documentation that the Lantus order had been clarified. Review of Resident #5's August 2026 electronic medication administration record (eMAR) from 08/01/26-08/06/26 revealed: -There was an entry for Lantus Solostar 100 units/mL, inject 12 units twice a day, scheduled at 8:00am and 8:00pm. -There was documentation that Lantus Solostar was administered twice daily at 8:00am and 8:00pm. Observation of Resident #5's medications on hand on 08/06/26 at 1:53pm revealed: -There was a Lantus Solostar pen labeled with Resident #5's name.	D 344		

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D 344	Continued From page 97 -The pen was to be discarded after 28 days, with a discard date of 08/17/26. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/06/26 at 10:16am revealed the order currently being used to fill Resident #5's Lantus Solostar was dated 05/09/26 and was to administer 12 units twice daily. b. Review of Resident #5's current FL2 dated 07/31/26 revealed there was an order for latanoprost (a prescription eye drop used to lower high pressure inside the eye) 0.0005% eye drops, one drop; there was no documentation of the frequency or which eye(s). Review of Resident #5's physician's orders and facility progress notes revealed no documentation that the latanoprost order had been clarified. Review of Resident #5's August 2026 eMAR from 08/01/26-08/06/26 revealed: -There was an entry for latanoprost 0.005% eye drops, instill one drop in each eye once daily at bedtime, scheduled at 8:00pm. -There was documentation that latanoprost was administered daily at 8:00pm. Observation of Resident #5's medications on hand on 08/06/26 at 1:53pm revealed: -There was a bottle of latanoprost eye drops dispensed on 07/10/26 with directions to instill one drop into both eyes once daily. -The bottle was to be discarded after 42 days, with a discard date of 08/11/26. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/06/26 at 10:16am revealed the order currently being used	D 344		

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D 344	Continued From page 98	D 344		

to fill Resident #5's latanoprost was dated 05/09/26 and was to administer one drop in each eye once daily at bedtime.

c. Review of Resident #5's current FL2 dated 07/31/26 revealed there was no order for diclofenac gel (used to treat pain/inflammation).

Review of Resident #5's August 2026 eMAR from 08/01/26-08/06/26 revealed:
-There was an entry for diclofenac sodium gel to apply 2 grams topically to shoulders, back, elbows, and knees three times daily; do not exceed 32 grams to all areas in 24 hours, scheduled at 8:00am, 2:00pm, and 8:00pm.
-There was documentation that diclofenac gel was applied three times daily at 8:00am, 2:00pm, and 8:00pm.
Review of Resident #5's physician's orders and facility progress notes revealed no documentation that the diclofenac gel order had been clarified.

Observation of Resident #5's medications on hand on 08/06/26 at 1:53pm revealed there was a tube of diclofenac gel that was dispensed on 07/10/26 with directions to apply 2 grams topically to shoulders, back, elbows, and knees three times daily; do not exceed 32 grams to all areas in 24 hours.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/06/26 at 10:16am revealed the order currently being used to fill Resident #5's diclofenac gel was dated 07/16/26 and was to apply 2 grams topically to shoulders, back, elbows, and knees three times daily; do not exceed 32 grams to all areas in 24 hours.

d. Review of Resident #5's current FL2 dated

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D 344	Continued From page 99 07/31/26 revealed there was no order FSBS, daily with parameters. Review of Resident #5's August 2026 eMAR from 08/01/26-08/06/26 revealed: -There was an entry to check Resident #5's FSBS twice daily, at breakfast and at bedtime, and to notify the primary care provider (PCP) if the FSBS was less than 70 or greater than 400, scheduled at 6:30am and 8:00pm. -There was documentation Resident #5's FSBS was checked twice daily at 6:30am and 8:00pm. Review of Resident #5's physician's orders and facility progress notes revealed no documentation that the FSBS order had been clarified. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/06/26 at 10:16am revealed the current order for Resident #5's FSBS was dated 05/09/26 and was to check the FSBS twice daily, at breakfast and at bedtime, and to notify the PCP if the FSBS was less than 70 or greater than 400. e. Review of Resident #5's current FL2 dated 07/31/26 revealed there was no order to check pulse or BP weekly with parameters. Review of Resident #5's August 2026 eMAR from 08/01/26-08/06/26 revealed: -There was an entry to check BP and pulse once weekly and to notify the PCP if the systolic BP was greater than 180 or less than 90, or the diastolic BP was greater than 110 or less than 60, scheduled at 8:00am. -There was documentation that Resident #5's BP and pulse were checked once weekly at 8:00am. Review of Resident #5's physician's orders and	D 344		

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D 344	Continued From page 100 facility progress notes revealed no documentation that the BP and pulse order had been clarified. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/06/26 at 10:16am revealed the current order for Resident #5's BP and pulse checks was dated 05/09/26 with directions to check BP and pulse once weekly and to notify the PCP if the systolic BP was greater than 180 or less than 90, or the diastolic BP was greater than 110 or less than 60. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable. _____ Telephone interview with a representative from the facility's contracted pharmacy on 08/07/26 at 11:58am revealed Resident #5's FL2 dated 07/31/26 was signed by the PCP on 07/31/26 had not been received at the pharmacy. Interview with Resident #5's PCP on 08/06/26 at 11:54am revealed: -She expected orders to be complete and accurate, and if there was any discrepancy, the orders needed to be clarified. -She did not recall anyone clarifying orders for Resident #5. Interview with the Resident Care Coordinator (RCC) on 08/07/26 at 11:28am revealed: -She completed Resident #5's FL2 for the PCP to sign. -She used the most recent physician's orders to complete the FL2. -She usually printed the physician's orders before she filled out the FL2, but she may have started filling out the FL2 before she did so. -If there were any changes to the FL2, she would	D 344		

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D 344	Continued From page 101 get the orders clarified. -She recalled someone, but did not recall who, telling her she needed to make sure the orders were complete, and she had not had time to make the corrections. -She had been out of the facility until 07/29/26 and had not had time to make the corrections. Interview with the Executive Director on 08/07/26 at 1:41pm revealed: -The RCC was responsible for completing the FL2s based on the information from the physician's orders. -The order needed to be complete and include the medication, the amount, the route, the frequency, and the time. -Once the FL2 was signed, the RCC should have compared the FL2 to the physician's order to ensure they matched, and if they did not, she should have had the orders clarified. Interview with the Administrator on 08/07/26 at 3:24pm revealed: -The RCC was responsible for completing Resident #5's FL2. -The RCC should print the physician's orders, write exactly what was on the physician's order from the FL2, and make sure the orders were complete.	D 344		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358		

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which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#1) for a medication used to treat acid reflux.

The findings are:

Review of Resident #1's current FL2 dated 07/14/26 revealed diagnoses included dementia and hypertension.

Review of Resident #1's signed physician orders dated 07/14/26 revealed there was an order for omeprazole (used to treat reflux) 20mg, one tablet daily; take on an empty stomach.

Review of Resident #1's primary care provider's (PCP) after-visit summary dated 07/30/26 revealed Resident #1's current order for omeprazole 20mg was once daily on an empty stomach.

Review of Resident #1's August 2026 electronic medication administration record (eMAR) from 08/01/26-08/06/26 revealed:
-There was an entry for omeprazole 20mg, take one tablet daily on an empty stomach, with a scheduled administration time of 8:00am.
-There was documentation that omeprazole was administered once daily from 08/01/26-08/06/26 at 8:00am.

Observation of Resident #1 on 08/06/26 at 7:09am revealed she was served breakfast.

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D 358	Continued From page 103 Interview with the medication aide (MA) on 08/06/26 at 7:13am revealed she had not administered any medications to Resident #1 that day, 08/06/26. Observation of Resident #1's medications on hand on 08/06/26 at 7:45am revealed: -Resident #1's medication was in a multi-dose package. -The multi-dose package contained 12 tablets, including omeprazole 20mg. -The multi-dose package was labeled as Thursday 08/06/26 morning medications. Second interview with the MA on 08/06/26 at 2:38pm revealed: -She usually administered Resident #1's medications after the resident had eaten breakfast. -At one time, Resident #1's omeprazole was dispensed in a single punch card. -She knew Resident #1's omeprazole was ordered to be administered on an empty stomach at one time. -Since the medication was now packaged together, she did not know it should be administered separately. -Resident #1 had not complained of any heartburn lately, but she had complained of a "funny feeling" in her chest about 5-6 months ago. Interview with Resident #1's PCP on 08/06/26 at 11:54am revealed: -Resident #1's omeprazole should have been administered on an empty stomach to ensure the medication was in her system before she ate. -Resident #1 was having issues with reflux, which was why the medication was ordered to be	D 358		

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D 358	Continued From page 104 administered on an empty stomach. -She expected medication orders to be followed as written. Interview with the Executive Director on 08/07/26 at 1:41pm revealed: -Resident #1's omeprazole should have been administered before meals as ordered. -If Resident #1's omeprazole was administered after she ate breakfast, it was not administered correctly, and the resident could have experienced reflux. Interview with the Administrator on 08/07/26 at 3:24pm revealed: -She did not know Resident #1's omeprazole was not being administered on an empty stomach. -She expected all medication orders to be followed exactly as ordered. -She would have expected staff to have notified her that the time of medication administration needed to be changed. Based on observations, record reviews, and interviews, it was determined Resident #1 was not interviewable.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's	D 366		

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D 366	Continued From page 105 medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the medication aide (MA) observed a resident take their medications. The findings are: Observation of a resident on 08/05/26 at 8:49am revealed: -The MA was about 10 feet away from the resident. -The resident had a cup of clear fluid and 4 tablets in her hand. -She was taking the medication 1 tablet at a time, followed by her drink. -The MA had redirected her attention to administering other residents' medications. Interview with the resident on 08/05/26 at 8:49am revealed she liked to take her own medicines with water away from everyone. Interview with the MA on 08/07/26 at 11:16am revealed: -The resident preferred to take her medications alone and away from the cart. -She kept the medication carts in the common area for early morning medication pass, because the internet did not always work and she was unable to sign off on the medications if the internet was not working. -She kept an eye on the resident while she initiated other medication preparations. -She was aware that she should watch one resident at a time take their medications. -She had no concerns that the resident would not	D 366		

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D 366	Continued From page 106 take her medication. Observation of the medication room on 08/06/26 at 1:48pm revealed: -The MA was walking away from the medication cart with medications in each hand. -There were two additional prepackaged medications lying on top of the medication cart. Observation of the medication room on 08/06/26 at 1:50pm revealed: -The MA returned to the medication cart without any medications in her hands, pulled the drawer out, took the two medications from the top of the cart, placed them in the top drawer, and locked the medication cart. -She did not document administering any medications. Interview with the Executive Director on 08/07/26 at 2:00pm revealed: -She was not aware that residents were given medications and allowed to walk away without the MA witnessing the medications had been swallowed. -Residents should be observed by the MA swallowing their medications. Interview with the Administrator on 08/07/26 at 3:49pm revealed: -Residents should be watched until they swallowed their medications. -The MAs were trained to watch residents take their medication because they could hold their medication and never swallow them.	D 366		
D 406	10A NCAC 13F .1009 (b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care	D 406		

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	HAL093010	A. BUILDING: _____ B. WING _____	R 08/07/2026

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D 406	Continued From page 107 (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow up on a pharmacy review recommendation for 2 of 5 sampled residents (#1 and #5). The findings are: 1. Review of Resident #1's current FL2 dated 07/14/26 revealed diagnoses included dementia and hypertension. Review of Resident #1's signed physician orders dated 07/14/26 revealed: -There was an order for metoprolol tartrate (used to lower blood pressure (BP) 50mg, one tablet twice daily, hold if heart rate drops below 50. -There was an order for BP checks once daily and to notify the primary care provider (PCP) if the systolic (SBP) was greater than 180 or the diastolic (DBP) was greater than 110 or less than 60, or if the heart rate was greater than 110 or less than 60. Review of Resident #1's emergency department (ED) discharge summary dated 05/17/26 revealed an order for metoprolol tartrate 50mg, one tablet twice daily, hold if the heart rate dropped below 50. Review of Resident #1's PCP's after-visit	D 406		

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D 406	Continued From page 108	D 406		

summary dated 05/21/26 revealed an order to add BP parameters and hold BP medication if the resident's BP was less than 90/60.

Review of the quarterly medication review for Resident #1 dated 07/23/26 revealed:
-The PCP note on 05/25/26 stated to hold BP medications if the BP was less than 90/60, and this parameter was not noted on the electronic medication administration record (eMAR) orders.
-Would the PCP like to add the holding parameter to the eMAR orders.
-The PCP had not agreed or disagreed with the recommendation and had not signed the pharmacy review to indicate it had been reviewed.

Review of Resident #1's eMAR for May 2026, June 2026, July 2026, and August 2026 from 08/01/26-08/06/26 revealed:
-There was an entry for metoprolol tartrate 50mg, one tablet twice daily, hold if heart rate drops below 50, with a scheduled administration time of 8:00am and 8:00pm.
-There was an entry for BP checks once daily and to notify the PCP if the SBP was greater than 180 or the DBP was greater than 110 or less than 60, or if the heart rate was greater than 110 or less than 60, scheduled at 8:00am.
-There were two times Resident #1's BP was documented below 90/60.
-There was no documentation to hold the metoprolol if the resident's BP was less than 90/60.

Interview with a pharmacist from the facility's contracted pharmacy on 08/07/26 at 11:58am revealed:
-A signed copy of the pharmacy review dated 07/23/26 had not been received by the pharmacy.

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-If the order to hold the metoprolol if Resident #1's BP was less than 90/60 was not implemented and the resident's BP was below this parameter, the resident's BP could have dropped further, causing the resident to become hypotensive and increased her risk of falls.

Interview with the Special Care Unit Coordinator (SCC) on 08/07/26 at 9:41am revealed:
-She was responsible for the pharmacy reviews for the SCU.
-She would send a message to the PCP for any recommendations that needed to be implemented immediately.
-She did not see where she had sent a message to the PCP for Resident #1.
-She printed out the pharmacy reviews and put them in the PCP's notebook to be reviewed weekly.
-She was concerned that the order for Resident #1's BP parameters was not implemented.

Interview with Resident #1's PCP on 08/06/26 at 11:54am revealed:
-Resident #1's parameters for her BP should have already been in place.
-She did not know the BP parameters she had ordered for Resident #1 were not implemented.
-She had not seen Resident #1's pharmacy review.
-If she had seen the pharmacy review, she would have agreed to add the BP parameters to the eMAR and signed it.
-It was concerning that Resident #1's BP medication was administered when it should have been held when her BP was already low, because the resident's BP could have "bottomed out," which could have made the resident feel bad and she could have passed out.

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D 406	Continued From page 110 Attempted telephone interview with the pharmacist who completed the pharmacy review dated 07/23/26 on 08/07/26 at 9:22am was unsuccessful. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 08/07/26 at 11:58am. Refer to the interview with the Executive Director on 08/07/26 at 1:41pm. Refer to the interview with the Administrator on 08/07/26 at 3:24pm. 2. Review of Resident #5's current FL2 dated 07/31/26 revealed: -Diagnoses included chronic kidney disease, type 2 diabetes, gastro-esophageal reflux disease (GERD), dementia, and hypertension. -There was an order for metformin (used to lower blood sugar) 500mg once daily with food. Review of the quarterly medication review for Resident #5 dated 07/23/26 revealed: -The pharmacist documented the resident received metformin 500mg daily and her estimated glomerular filtration rate (eGFR) (a blood test score that measures how well the kidneys filter waste) was 37.6 in 02/26. -The risk versus benefit assessment was recommended if the eGFR was less than 45. -The primary care provider (PCP) documented to discontinue the metformin, and she would recheck the resident's A1C (blood test that measured the average blood sugar levels over the past two to three months) and eGFR in a month and see where the levels were, as the current A1C was 5.5, which was well controlled. -The pharmacy review was signed by the PCP on	D 406		

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D 406	Continued From page 111 07/30/26 at 12:28pm. Interview with a pharmacist from the facility's contracted pharmacy on 08/07/26 at 11:58am revealed: -A copy of the pharmacy review dated 07/23/26 signed by the PCP on 07/30/26 had not been received by the pharmacy. -If Resident #5 continued to receive metformin, it increased the resident's risk of further lowering her eGFR and could cause the resident to become hypoglycemic, which could increase her risk of falls. Interview with the Special Care Unit Coordinator (SCC) on 08/07/26 at 9:41am revealed: -She was responsible for the pharmacy reviews for the resident in the SCU. -Once the PCP signed the pharmacy review, she sent the review to the pharmacy. -She had not sent Resident #5's signed pharmacy review to the pharmacy because she was told the Executive Director needed to review it first. Interview with the Executive Director on 08/07/26 at 1:41pm revealed she did not tell the SCC to hold Resident #5's signed pharmacy review and the SCC had misunderstood. Telephone interview with Resident #5's PCP on 08/07/26 at 4:56pm revealed: -The staff at the facility sent her the pharmacy review. -She reviewed and commented on the pharmacy review through a Docusign system. -The facility staff would then be notified of what changes were made. -She was concerned Resident #5's metformin was not discontinued per her order. -Resident #5 already had impaired kidney	D 406		

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D 406	Continued From page 112 function, and continuing on the medication could have affected her kidneys "down the road". -She would have expected Resident #5's metformin to have been discontinued within 72 hours of the order to discontinue. Attempted telephone interview with the pharmacist who completed the pharmacy review dated 07/23/26 on 08/07/26 at 9:22am was unsuccessful. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 08/07/26 at 11:58am. Refer to the interview with the Executive Director on 08/07/26 at 1:41pm. Refer to the interview with the Administrator on 08/07/26 at 3:24pm. _____ Telephone interview with a representative from the facility's contracted pharmacy on 08/07/26 at 11:58am revealed pharmacy recommendations were made by a pharmacist, reviewed by the PCP, and when the changes were received back at the pharmacy, the changes were implemented as new orders. Interview with the Executive Director on 08/07/26 at 1:41pm revealed: -The pharmacist gave the pharmacy reviews to the SCC, who was responsible for sending the reviews to the PCP. -The PCP was at the facility once a week. -Once the PCP signed the pharmacy review, the SCC should review the recommendations made by the PCP to ensure the changes were implemented. -The orders should be implemented within 1-2	D 406		

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D 406	Continued From page 113 days of the PCP signing the pharmacy review. -She did not know who sent the signed pharmacy review to the pharmacy if orders needed to be added to the eMAR, but the facility staff were responsible for making sure the changes were implemented. Interview with the Administrator on 08/07/26 at 3:24pm revealed the pharmacy reviews were sent to the pharmacy by the PCP.	D 406		