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	HAL051047	A. BUILDING: _____ B. WING _____	R 08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW ASSISTED LIVING CENTER	250 HIGHWAY 210 WEST SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on August 18, 2026 through August 20, 2026.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the front entrance/exit door had a continuous sounding device that was activated and audible throughout the facility when the door was opened and accessible to 1 of 1 sampled resident (#5) who was documented and known to be disoriented.	D 067		

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D 067	Continued From page 1 The findings are: Observations of the facility's front entrance/exit door on 08/18/26 at various times from 8:30am to 5:00pm revealed: -There was no audible sound when the door was opened. -There were no staff present at the front entrance of the facility. Observations of the front entrance/exit door on 08/19/26 at intervals from 7:25am to 4:45pm revealed there was no audible sound heard to alert staff when the door was opened. Observation of the facility's front entrance/exit door on 08/20/26 at 8:10am revealed: -There was no audible sound when the door was opened. -There was no staff present at the front entrance of the facility. Review of Resident #5's current FL-2 dated 08/19/26 revealed: -Diagnoses included vascular dementia, unspecified severity without behavioral disturbances. -The resident was ambulatory. -The resident was intermittently disoriented. Review of Resident #5's care plan and assessments dated 08/12/25 and 08/19/26 revealed: -The resident required mealtime reminders. -The resident was forgetful and needed reminders. Review of Resident #5's Resident Register revealed:	D 067		

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D 067	Continued From page 2 -There was no date documented in the section for date of admission. -The signature date for resident register was 07/31/25. -The resident was forgetful and needed reminders. -The resident's activity interest included walking. Interview with Resident #5 on 08/18/26 at 9:03am revealed the resident stated her first name and replied "don't know, I try to do something" when asked her last name. Second interview with Resident #5 on 08/19/26 at 8:06am revealed: -She thought the day of the week was Sunday. -She did not remember her room number. -She did not know the name of the facility where she lived. Interview with a medication aide (MA) on 08/18/26 at 9:03am revealed Resident #5 had dementia. Observations of Resident #5 on 08/19/26 at 8:27am revealed the resident approached another resident room, opened the door and attempted to enter the room when the MA redirected Resident #5 from the other resident's room door. -At 8:39am, Resident #5 walked to the front entrance/exit door and immediately turned around. Interview with a second MA on 08/19/26 at 7:55am revealed: -There were confused residents living at the facility. -She identified Resident #5 as a confused resident.	D 067		

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-Resident #5 walked around the facility all day.
-She felt like Resident #5 would soon need placement in a memory care unit.
-Resident #5's family member had voiced concerns about Resident #5's behavior of putting her toothpaste in the refrigerator.

Interview with a personal care aide (PCA) on 08/20/26 at 8:15am revealed:
-The PCA worked on the 3:00pm-11:00pm shift.
-The front entrance/exit door was locked at 12:00am (midnight) by the MAs.
-There was no audible sound heard when the front entrance/exit door was opened.
-Staff would not know if anybody went outside the front entrance/exit door.
-Staff made rounds every hour and checked the doors.

Interview with the Maintenance Director on 08/19/26 at 12:00pm revealed:
-There was no device that he could place on the front entrance/exit door that could be heard by staff if the door was opened.
-It had never been bought to his attention that exit doors at the facility needed to have an audible sounding device.
-He contacted a door company, but they would not be at the facility until the following week.

Second interview with the Maintenance Director on 08/20/26 at 8:25am revealed:
-There was no sounding device on the front entrance/exit door.
-He thought staff physically locked the front entrance/exit door around 6:00pm, but it might be 8:00pm or 9:00pm.

Telephone interview with Resident #5's family member on 08/20/26 at 4:30pm revealed:

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D 067	Continued From page 4 -Resident #5 was admitted to the facility on 08/04/25. -The resident liked to walk. -There was a deficit with Resident #5's short term memory. Interview with the Administrator on 08/18/26 at 4:00pm revealed: -She was not aware of any residents living at the facility who were assessed to be disoriented. -She had not reviewed all resident's FL-2s who lived at the facility. -She was not aware of the need for an audible sounding device on entrance/exit doors in facilities with residents who had been assessed as confused or disoriented. -Resident #5 walked around the facility a lot. -She had never seen Resident #5 try to go outside or wander into any other resident's room. -She did not realize Resident #5 was assessed to be intermittently disoriented on the current FL-2. -She had been at the facility for about six months and there had not been any sounding device on the front entrance/exit door. Second interview with the Administrator on 08/20/26 at 8:44am revealed: -There was nothing currently in place to secure the front entrance/exit door except the MAs locking the door at night. -She knew there were residents at the facility with a diagnosis of dementia but did not have knowledge of residents in the facility with disorientation. Attempted telephone interview with Resident #5's primary care provider (PCP) on 08/20/26 at 11:38am was unsuccessful. The facility failed to ensure the front entrance/exit	D 067		

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D 067	Continued From page 5 door had a continuous sounding alarm that was activated and audible throughout the facility when the door was opened and accessible to a resident (#5) who was documented to be intermittently disoriented. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 08/20/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 4, 2026.	D 067		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record	D 113		

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review, the facility failed to ensure hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 6 of 8 fixtures used by residents.

The findings are:

Review of hot water temperature guidelines referenced by the American Society for Hospital Engineering revealed:
-A hot water temperature of 120 degrees F could cause first degree burns within 8 minutes and second degree burns within 10 minutes.
-A hot water temperature of 124 degrees F could cause first degree burns within 2 minutes and second degree burns within 4.2 minutes.
-A second degree burn affected both the outer and second layer of skin and may cause blistering.

Review of the facility's local Environmental Health inspection report dated 05/22/26 revealed:
-On hallway 1, the water temperature was 122 degrees Fahrenheit (F).
-On hallway 2, the water temperature was 122 degrees F.
-On hallway 3, the water temperature was 122 degrees F.
-Throughout the facility hot water was at 120-123 degrees F.

Observations of water temperatures at fixtures accessible for resident use on 08/18/26 between 9:23am and 10:22am revealed:
-At 9:23am, the hot water temperature at the sink fixture in the bathroom between resident rooms 301 and 303 on the 300 hall was 124.8 degrees F; there was steam visibly coming from the water at the sink fixture.
-At 9:24am, the hot water temperature at the sink

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fixture in the bathroom of resident room 109 was 123.1 degrees F.
-At 9:26am, the hot water temperature at the sink fixture in the bathroom between resident rooms 210 and 212 was 121.5 degrees F.
-At 9:32am, the hot water temperature at the sink fixture in the bathroom between resident rooms 301 and 303 on the 300 hall was 123.6 degrees F; there was steam visibly coming from the water at the sink fixture.
-At 9:38am, a recheck of the hot water temperature at the sink fixture in the bathroom between resident rooms 301 and 303 on the 300 hall, with the Administrator present, was 123.6 degrees F; there was steam visibly coming from the water at the sink fixture.
-At 9:46am, the hot water temperature at the sink fixture in the bathroom between resident rooms 302 and 304 on the 300 hall was 120.9 degrees F; there was steam visibly coming from the turned-on water at the sink fixture.
-At 10:22am, the hot water temperature at the sink fixture in the bathroom of resident room 309 on the 300 hall was 121.2 degrees F; there was steam visibly coming from the water at the sink fixture.

At 9:38am the Administrator was requested to post caution signs notifying staff and residents of the hot water.

Interview with a resident in room 301 on 08/18/26 at 9:26am revealed:
-The hot water temperature at the sink fixture was "pretty good, not too hot".
-The cold water did not get very cold.
-She mixed the hot water and cold water when she used the sink fixture.
-She liked the water temperature to be lukewarm.
-She had not seen anyone at the facility checking

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D 113	Continued From page 8 water temperatures. Interview with a second resident who resided in a room on the 300 hall on 08/18/26 at 9:52am revealed sometimes the water temperature was too hot and sometimes the water temperature was too cold. Interview with a third resident who resided in a room on the 300 hall on 08/18/26 at 10:22am revealed sometimes the water temperature was pretty warm but not too hot. Interview with the Administrator on 08/18/26 at 9:38am revealed: -She could see steam coming from the turned-on water at the sink fixture in the bathroom between resident rooms 301 and 303 on the 300 hall. -The steam meant the water temperature was too hot. -Waterless tanks were used at the facility to provide the hot water to the entire building. -There had been a facility inspection not too long ago and the hot water temperatures were high. -A maintenance person from another facility came to the facility and was supposed to have gotten the water temperatures regulated. -She was not sure if the hot water temperatures at the facility had been regulated. -The current Maintenance Director at the facility had been checking hot water temperatures on 08/18/26 and the hot water temperatures ranged from 118 degrees F to 120 degrees F. Second observations of hot water temperatures in the facility on 08/18/26 from 9:58am to 10:23am revealed: -At 10:03am, the hot water temperature at the sink fixture in the bathroom between resident rooms 301 and 303 on the 300 hall was 121.4	D 113		

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degrees F with the surveyor thermometer and 120.4 degrees F with the facility thermometer; there was no steam visibly coming from the water at the sink fixture.
-At 10:23am, the hot water temperature at the sink fixture in the bathroom of resident room 309 on the 300 hall was 121.2 degrees F with the surveyor and facility thermometers.

Observations of hot water temperatures in the facility on 08/18/26 between 4:25pm and 4:40pm revealed:
-At 4:25pm, the hot water temperature at the sink fixture in the bathroom of resident room 109 was 119.3 degrees F.
-At 4:28pm, the hot water temperature at the sink fixture in the bathroom between resident rooms 210 and 212 was 120.7 degrees F.
-At 4:33pm, the hot water temperature at the sink fixture in the bathroom between resident rooms 301 and 303 on the 300 hall was 118.4 degrees F; there was no steam visibly coming from the turned-on water at the sink fixture.
-At 4:34pm, the hot water temperature at the sink fixture in the bathroom between resident rooms 302 and 304 on the 300 hall was 117.6 degrees F.
-At 4:40pm, the hot water temperature at the sink fixture in the bathroom of resident room 309 on the 300 hall was 117.3 degrees F.

Interview with the Maintenance Director on 08/18/26 at 10:06am revealed:
-The hot water temperature at the sink fixture in room 301 felt too hot.
-There were "three or four" tankless hot water heaters used to supply hot water to the facility.
-He was told the tankless hot water heaters used at the facility should not be set over 127 degrees F.

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D 113	Continued From page 10 -He thought the tankless hot water heaters used at the facility were set at 127 degrees F. Second interview with the Maintenance Director on 08/19/26 at 11:55am revealed: -He had not checked any water temperatures at the facility prior to 08/18/26. -He had only been checking the temperatures of the hot water tanks daily. Observations of the tankless hot water heaters on 08/18/26 at 10:08am revealed there were four tankless hot water heaters with visible thermostat readings for 127 degrees F attached to the back outside wall of the facility. Interview with a local electrical plumbing service representative on 08/18/26 at 1:12pm revealed: -He had just inspected the facility hot water supply system. -He found four tankless hot water heaters set at 127 degrees F. -There was corrosion on the outside of the mixing valve. -He did not want to adjust the mixing valve because of the corrosion. -The corrosion on the mixing valve presented an issue. -He lowered the water temperatures of the tankless hot water heaters to 120 degrees F. -The hot water temperatures should range from 100 degrees F to 116 degrees F. Interview with the Administrator on 08/20/26 at 4:15pm revealed: -She was not aware of hot water temperatures at the facility until discovered by the surveyors. -She expected hot water temperatures to be checked twice weekly. -She expected the Maintenance Director to notify	D 113		

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D 113	Continued From page 11 her of hot water temperature readings. _____ The facility failed to ensure water temperatures were maintained at a minimum of 100 degrees F and a maximum of 116 degrees F related to sink fixture water temperatures ranging from 117.3 degrees F to 124.8 degrees F at 6 of 8 fixtures accessible for use by residents. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 08/18/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 4, 2026.	D 113		
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on	D 253		

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D 253	Continued From page 12 how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10) skin integrity; (11) memory, orientation and cognition; (12) vision and hearing; (13) speech and communication; (14) assistive devices needed; and (15) a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-hom	D 253		

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D 253	Continued From page 13 e-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete an annual assessment for 1 of 5 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 12/09/25 revealed diagnoses included hypothyroidism, urinary incontinence, history of non-Hodgkin lymphoma and asthma. Review of Resident #1's Resident Register revealed she was admitted to the facility on 04/23/25. Review of Resident #1's record on 08/18/26 revealed the last annual assessment was completed on 05/06/25. Interview with the Resident Care Director (RCD) on 08/18/26 between 8:30am and 9:00am revealed she started with the company about 3 weeks ago.	D 253		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW ASSISTED LIVING CENTER	250 HIGHWAY 210 WEST SMITHFIELD, NC 27577

(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 253	Continued From page 14 Interview with the Administrator on 08/20/26 at 12:11pm revealed: -She started working with the facility in January 2026. -She had not audited any residents' records to ensure the assessments were completed. -The RCD was responsible for ensuring the assessments were completed annually. -She was not aware Resident #1 had an overdue assessment.	D 253		
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 and interviews, the facility failed to provide feeding assistance to Resident #1 upon receipt of her meal. The findings are: Review of Resident #1's current FL-2 dated 12/09/25 revealed diagnoses included hypothyroidism, urinary incontinence, history of non-Hodgkin lymphoma and asthma. Observation during the lunch meal on 08/19/26 between 12:00pm and 1:00pm revealed: -At 12:20pm, a dietary staff brought Resident #1's tray to the nurses' station and placed it on the	D 312		

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D 312	Continued From page 15 desk. -The medication aide (MA) was sitting at the nurses' station. -At 12:26pm, Resident #1's tray was still sitting on the nurses' station desk. -The MA was prompted by a personal care aide (PCA) to come to a resident's room. -At 12:33pm, the MA and the PCA came down the fall from another resident's room. -The PCA walked toward the dining room. -At 12:36pm, the PCA went to the nurses' station and picked up Resident #1's tray. -The PCA took Resident #1's tray to her room and set it up. -At 12:39pm, Resident #1 started to drink her beverages. -At 12:41pm, the PCA left Resident #1's room and returned. -Between 12:42 and 12:45pm, the PCA sat next to Resident #1 and asked her if she was hungry; Resident #1 nodded yes. -The PCA gave Resident #1 a spoon full of her meal. -Resident #1 ate the food in the spoon and refused the remainder of her meal. -Resident #1 would not confirm or deny if her meal was hot enough. Interview with the PCA on 08/19/26 at 12:45pm revealed: -She was assisting another resident with personal care when Resident #1's tray was delivered to the nurses' station. -Resident #1 usually ate in her room. -The dietary staff usually delivered Resident #1's tray in her room and would inform a PCA the tray was left in her room. -The dietary staff should have delivered Resident #1's tray when she was available.	D 312		

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D 312	Continued From page 16 Interview with a MA on 08/19/26 at 12:50pm revealed: -She asked the dietary staff to prepare Resident #1's tray. -Resident #1's tray should not have sat too long at the nurses' station. Interview with the Administrator on 08/19/26 at 1:07pm revealed: -She expected staff to pick up Resident #1's tray from the kitchen. -There should not have been any time delay feeding Resident #1.	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: Based on observations and interviews, the facility failed to ensure residents were treated with respect and dignity as evidenced by the tone of voice which staff spoke to residents. The findings are: Confidential interview with a resident revealed: -There was a staff member on third shift that was "rude". -The staff member "did not want to turn the air conditioner on but did get it right". Second interview with the resident revealed: -A staff member came to her room and stuck her tongue out and then turned around.	D 338		

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-She did not think the staff member liked her.
-She tried to tell the Administrator about the staff member.

Confidential interview with a second resident revealed:
-Different staff members (un-named) at the facility would tell her that she could not press her call bell if her need was not an emergency.
-She requested a staff member to provide toilet paper once and was told that was not an emergency, and a fall would be considered an emergency.
-A staff person "got on me because I rung the bell - she made me go turn the bell off and said you can get up and turn that off too because it's not an emergency". She was unsure of the staff name and the exact date of occurrence.
-She had not reported anything to the Administrator or staff but had told a family member.

Second interview with the second resident revealed:
-She had been told by MAs and personal care aides not to pull the call light unless it was an emergency.
-She sometimes got dizzy, was unable to stand up, and felt like she was going to pass out.
-Sometimes her feelings were hurt when staff members would tell her not to press the call light for assistance.
-She tried to ignore staff.
-A staff member told her if she kept ringing the call bell, she would be sent out of the facility with behavior issues and would not be allowed to return.
-She did not have anywhere else to go.

Observation of the resident during the second

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interview revealed the resident became tearful as she spoke.

Telephone interview with the second resident's family member on 08/19/26 at 3:13pm revealed:
-The resident told her that staff members had told the resident that she was going to be sent out of the facility for ringing the call bell a lot and not to ring the call bell unless there was an emergency.
-The resident told her staff members were impatient and "snap at her".
-On one occasion she was on the telephone with the resident when a staff member came in the resident's room and "was hateful in the way she spoke".
-She had contacted the facility corporate office in the past because a staff member told her "you can call anybody you want to" when she informed the staff member that she was going to call.

Second telephone interview with the family member on 08/20/26 at 1:12pm revealed:
-She called the corporate office about one year ago regarding staff behavior.
-When the staff members saw her walk into the facility, "things change".
-She could not provide a timeframe for any of the occurrences.
-She did not feel it made a difference that the facility had a new Administrator because "the people act the same".

Interview with the Administrator on 08/19/26 at 3:37pm revealed:
-A resident had told her that staff were not kind, and did not speak to the resident nicely.
-She had addressed the residents' concern with staff in a staff meeting and during the morning stand-ups meetings with staff.
-She conducted stand-up meetings with first shift

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D 338	Continued From page 19 staff only and expected the medication aides (MA) to share the information with oncoming MAs but could not say she knew information was being passed on to oncoming staff. -She spoke to staff about two weeks ago about the residents' concerns. -She told staff that they have to be kind, respectful, and patient with the residents. -There had not been any other concerns voiced to her by any other residents. -She did not think any family members had mentioned any concerns regarding staff behavior. -There had not been any resident rights training conducted since becoming the Administrator at the facility. -She knew resident rights training was conducted upon hire for new employees. -She had not had any conversations with the corporate office staff regarding any concerns with residents. Second interview with the Administrator on 08/20/26 at 4:15pm revealed: -She expected staff to follow resident rights. -She expected staff to talk to the residents respectfully no matter what.	D 338		