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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001023	A. BUILDING _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAKEY HALL	501 NORTH MANNING AVENUE ELON, NC 27244

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 07/21/26 to 07/22/26.	D 000		
D 195	10A NCAC 13F .0608 (c-f) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents (c) The aide shall provide personal care services and supervision needed by the residents. (d) Aides shall not provide housekeeping duties except: (1) Between the hours of 7:00 a.m. to 9:00 p.m . (A) to prevent an accident or injury; (B) when occasionally attending to an individual resident housekeeping need; and (C) when the number of aides on duty exceeds the minimum required by Paragraph (a) of this Rule. (2) Between the hours of 9:00 p.m. to 7:00 a.m., as long as the housekeeping duties do not: (A) hinder the aide's care of residents or immediate response to resident calls; (B) do not disrupt the residents' normal lifestyles and sleeping patterns; and (C) do not take the aide out of view of where the residents are as the aide shall be prepared to care for the residents since that remains his or her primary duty. (e) Aides shall not be assigned food service duties except when providing assistance to individual residents who need help with eating and carrying plates, trays, or beverages to residents. (f) In addition to the staffing required for management and aide duties, there shall be additional staff to perform housekeeping and food service duties.	D 195	Please See Attached for Review -Ed Weeks	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Exec. Director | (X6) DATE: 8/24/26

STATE FORM 6899 Q32W11 If continuation sheet 1 of 16

The Plam of Correction with addendum was reviewed and acknowledged on 08/27/26. Refer to addendums per telephone call with the Executive Director for tag numbers #195, #296, #312, and #344 for this Statement of Deficiencies.

PD 08/27/26

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D 195	Continued From page 1 Note: The following chart illustrates the required aide, supervisory and management staffing requirements for each eight-hour shift in facilities with a census of 21 or more residents according to Rules .0602, .0603, .0604, .0608, and .0609 of this Section. Bed Count Position Type First Shift Second Shift Third Shift 21 - 30 Aide 16 16 8 Supervisor Not Required Not Required Not Required Administrator In the building, or within 500 feet and immediately available. 31-40 Aide 16 16 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 41-50 Aide 20 20 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 51-60 Aide 24 24 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 61-70 Aide 28 28 24 Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator On call 71-80 Aide 32 32 24 Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator On call 81-90 Aide 36 36 24	D 195		

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D 195	Continued From page 2	D 195		

Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
91-100 Aide 40 40 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
121-130 Aide 52 52 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
151-160 Aide 64 64 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
161-170 Aide 68 68 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
171-180 Aide 72 72 48
Supervisor 16 16 8

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D 195	Continued From page 3 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 181-190 Aide 76 76 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 191-200 Aide 80 80 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 201-210 Aide 84 84 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 211-220 Aide 88 88 64 Supervisor 16 16 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 221-230 Aide 92 92 64 Supervisor 16 16 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 231-240 Aide 96 96 64 Supervisor 24 24 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure personal care aides (PCA) and medication aides (MA) were not routinely assigned to perform food service duties in the Special Care Unit (SCU) such as plating and serving the meal, clearing the dining room tables	D 195		

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D 195	Continued From page 4 of used place settings and cleaning the dining room table, washing the used dishes from the meal, and mopping the kitchenette floor. The findings are: Observation of the lunch meal on 07/21/26 at various times between 11:57am and 12:45pm revealed: -At 12:09pm, the MA stopped feeding a resident, went to the kitchenette to prepare a plate of food for a resident who entered the dining room late. -At 12:16pm, the MA stopped feeding a resident, went to the kitchenette, retrieved the desserts and served the desserts to the residents. Interview with a PCA on 07/21/26 at 2:20pm revealed: -She served the residents cereal and milk each morning before the dietary staff brought the food to the SCU for the breakfast meal. -The dietary staff placed the food on the steam table when it was brought to the SCU. -The PCAs and MA plated the food and served the food and liquids. -There was no dietary staff available to assist with serving the meals in the SCU. Interview with a MA on 07/21/26 at 2:40pm revealed: -She was constantly interrupted while feeding residents at each meal. -The dietary staff delivered the food to the SCU and placed it on the steam table but did not stay in the SCU to plate the food, wash the dishes, and clean the dining room and kitchenette. -The MA was responsible for plating the food, serving the food, cleaning the dining room tables, washing the dishes and mopping the kitchenette floor.	D 195		

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D 195	Continued From page 5 -The PCAs served the drinks and placed the silverware and napkins on the dining room table and helped with clearing the dining room tables after everyone had eaten. Interview with the lead MA on 07/21/26 at 2:58pm revealed: -The MAs served the meals and cleaned up the dining room and kitchen after the meals. -As the lead MA, she had additional kitchen duties, such as feeling the cereal dispenser and the juice dispenser and ensuring there were napkins and straws available for the residents. -The dietary staff did not assist during the serving or the clean-up of the meals in the SCU. -She had mentioned to management that the SCU needed assistance during mealtimes, but she did not remember when she had mentioned it. Interview with the Special Care Coordinator (SCC) on 07/22/26 at 1:10pm revealed: -The dietary staff would deliver the food to the SCU but the dietary staff had never stayed to assist with serving the meal or helping with cleaning after the meal. -The MAs were responsible for plating the food, serving the plates of food, cleaning the dining room tables, washing the dishes and mopping the kitchenette floor. -She did not know a dietary staff was needed to assist with each meals so the MAs and PCAs would not be interrupted from feeding the residents. Interview with the Administrator on 07/22/26 at 3:35pm revealed: -He was active in the Alzheimer's Association and had learned that the less amount of people in the SCU, the better the resident reacted.	D 195		

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D 195	Continued From page 6 -The resident's behavior would be better based on the familiarity of the staff. -He had been employed for 10 years, and the meal service had not changed.	D 195		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have matching therapeutic menus for the guidance of food service staff for 2 of 2 sampled residents (#2, #3) with physician orders for Low Concentrated Sweets (LCS) (#2), and an International Dysphagia Diet Standardization Initiative 6 (IDDSI6) (#3). The findings are: Observation of the kitchen on 07/21/26 at 9:20am revealed there was no therapeutic diet menu available for staff to follow while preparing and serving meals. Review of the facility's menus on 07/21/26	D 296		

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D 296	Continued From page 7 revealed: -There was a seven day week at a glance menu. -There were no therapeutic diet menus for a Low Concentrated Sweets (LCS) diet, or an International Dysphagia Diet Standardization Initiative level 6 (IDDSI6) (a soft and bite-sized diet designed for residents who had trouble swallowing). 1. Review of Resident #2's current FL-2 dated 07/09/26 revealed: -Diagnoses included type 2 diabetes, hypertension, dementia and chronic kidney disease. -There was an order for a Low Concentrated Sweets (LCS) diet. Review of Resident #2's signed physician's order dated 11/13/25 revealed a diet order for a LCS diet. Refer to the interview with a cook on 07/21/26 at 9:20am. Refer to Interview with the Dietary Manager on 07/21/26 at 9:30am. Refer to Interview with the Administrator on 07/22/26 at 2:45pm. 2. Review of Resident #3's current FL-2 dated 10/02/25 revealed: -Diagnosis included dementia, and gastroesophageal reflux disease (GERD). -There was an order for an International Dysphagia Diet Standardization Initiative 6 (IDDSI6). Refer to the interview with a cook on 07/21/26 at 9:20am.	D 296		

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D 296	Continued From page 8 Refer to Interview with the Dietary Manager on 07/21/26 at 9:30am. Refer to Interview with the Administrator on 07/22/26 at 2:45pm. Interview with a cook on 07/21/26 at 9:20am revealed: -There were no residents with physicians' ordered [therapeutic] diets. -She followed the week at a glance menu and there were no other menus for her to follow. -She did not prepare any of the residents food differently; she prepared all of the food the same way for all of the residents. Interview with the Dietary Manager on 07/21/26 at 9:30am revealed: -There were only two therapeutic diets offered for residents; LCS and IDDSI6 diets. -The kitchen staff did not follow a therapeutic diet menu when preparing meals for the residents. -The staff served sugar free items including sugar free beverages, and desserts or half portions of desserts for the LCS diet. -The staff cut up meats for residents who were ordered the IDDSI6 diet. -There were no guidelines or parameters on the week at a glance menu for the cooks or staff to follow. Interview with the Administrator on 07/22/26 at 2:45pm revealed: -He was not aware the kitchen staff did not have a therapeutic diet menu to use and follow when preparing meals. -The Dietary Manager was responsible for making sure there was a therapeutic diet menu for the staff to follow.	D 296		

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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 ensure residents requiring assistance with meals in the Special Care Unit (SCU) were assisted upon receipt of meals in a manner that was unhurried and were served with dignity and respect. The findings are: Observation of the breakfast meal on 07/21/26 at various times between 8:15am and 8:32am revealed: -There were 12 of 16 residents seated in the dining room for the breakfast meal. -There were four residents seated at one table that required assistance with feeding. -The four resident's plates were served, and the food was partially eaten. -A personal care aide (PCA) sanitized her hands, donned gloves, entered the dining room, sat between the first and second residents, and continued feeding both residents, alternating from one to the other. -The PCA was observed feeding the residents with a fork and picking up sausage with her gloved hands for the residents to bite. -The PCA wore the same pair of gloves while	D 312		

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D 312	Continued From page 10 feeding both residents. -The medication aide (MA) sanitized her hands, donned gloves, entered the dining room and continued feeding the third resident and encouraging the fourth resident to eat. Observation of the lunch meal on 07/21/26 at various times between 11:57am and 12:45pm revealed: -The four residents who required feeding were served their lunch meal. -The first PCA fed the first resident without interruption. -The first resident ate 100% of her meal. -The second PCA fed the second resident and assisted/encouraged the third resident to eat. -The second PCA was alternating feeding the second and third resident. -During the meal the second PCA went to a resident at another table who had finished eating, took two empty cups from her hand and placed them on the dining room table and asked the resident to sit back down at the table. -The PCA did not change gloves or sanitize her hands after handling the resident's cups. -At 12:03pm the MA sat beside the fourth resident and began to feed her. -At 12:09pm, the MA went to the kitchenette to prepare a plate of food for a resident who entered the dining room late and returned to feeding after sanitizing her hands and changing her gloves. -At 12:16pm, the MA went to the kitchenette, retrieved the desserts and served the desserts to the residents. -At 12:25pm, the MA returned to feeding the fourth resident. -At 12:33pm, the MA stopped feeding the fourth resident to assist a resident from the dining room to the bathroom; -At 12:37pm; the Special Care Coordinator (SCC)	D 312		

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D 312	Continued From page 11 noticed the fourth resident was not being fed, and started feeding her. -At 12:43pm, the SCC was interrupted by a staff from an outside agency and stopped feeding the fourth resident. -At 12:45, the MA returned to feed the fourth resident. -The fourth resident ate about 75 % of her lunch meal. Interview with a PCA on 07/21/26 at 2:20pm revealed: -She was not in the dining room this morning when the surveyor entered the dining room because an alarm from a resident's room had sounded and she went with the MA to check on the resident. -She returned to feed the first resident and the second resident their breakfast. -The staff typically was interrupted while feeding the residents. -They did not have enough staff to feed residents one on one. -No one had instructed her to feed one resident at a time without interruptions. Interview with a MA on 07/21/26 at 2:40pm revealed: -That morning during breakfast a resident attempted to get out of bed and her alarm sounded. -She and a PCA left the dining room and feeding residents to check on the resident who attempted to get out of bed. -The staff was constantly interrupted while feeding residents at each meal. -There were four residents who required feeding and a PCA had to feed more than one resident at a time. -The MA was responsible for plating the food, so	D 312		

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D 312	Continued From page 12 when a resident entered the dining room late, she had to stop feeding a resident and plate the resident's food. -After most of the residents had finished their main course, she had to serve the desserts. -She would have to stop feeding a resident to serve the desserts. Interview with the lead MA on 07/21/26 at 2:58pm revealed: -There were only 2 PCAs and 1 MA during mealtime and there were four residents to feed. -One of the PCAs had to feed two residents and the other PCA had to feed one resident and encourage or feed the fourth resident. -She had mentioned to management that the SCU needed assistance during meals times but she did not remember when she had mentioned it. Interview with the SCC on 07/22/26 at 1:10pm revealed: -The SCU had two PCAs and a MA who assisted with feeding. -The PCAs would have to feed two residents at a time in order to get all the resident fed. -The SCU had not had four feeders at one time; this was the most feeders the SCU had at one time. -She assisted with feeding when needed and the Activities Director would assist with feeding also. Interview with the Administrator on 07/22/26 at 3:35pm revealed: -The PCAs usually feed two residents at one time. -There were more feeders in the SCU now than ever before.	D 312		

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D 344	Continued From page 13	D 344		
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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify a medication order for 1 of 5 sampled residents (#5) related to a medication for pain. The findings are: Review of Resident #5's current FL-2 dated 07/21/26 revealed: -Diagnoses included heart failure, chronic kidney disease, and dementia without behaviors. -There was an order for acetaminophen 500mg (used to treat pain) every 4 hours as needed (PRN) for pain. -There was no order for acetaminophen 500mg every 8 hours for right shoulder pain. Review of Resident #5's signed physician order dated 07/09/26 revealed there was an order for	D 344		

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	HAL001023	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAKEY HALL	501 NORTH MANNING AVENUE ELON, NC 27244

(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 344	Continued From page 14 acetaminophen 500mg every 8 hours for right shoulder pain. Review of Resident #5's July 2026 electronic medication administration record (eMAR) from 07/09/26 to 07/22/26 revealed: -There was an entry for acetaminophen 500mg every 8 hours for right shoulder pain with a scheduled administration time of 6:00am, 2:00pm, and 10:00pm. -There was documentation that acetaminophen 500mg was administered every 8 hours from 07/10/26 at 10:00pm to 07/22/26 at 6:00am. Observation of Resident #5's medication on hand on 07/22/26 at 10:30am revealed: -There were three punch cards of acetaminophen 500mg on the medications cart with a dispensed date of 07/20/26. -The first punch card was labeled in the morning, the second punch card was labeled afternoon, and the third punch card was labeled night. -There were 27 of 30 acetaminophen tablets remaining in the morning punch card. -There were 28 of 30 acetaminophen tablets remaining in the afternoon and night punch card. Telephone interview with a representative from the facility's contracted pharmacy on 07/22/26 at 11:36am revealed: -Resident #5 had an order for acetaminophen 500mg one tablet every 8 hours for shoulder pain. -The pharmacy dispensed 28 acetaminophen 500mg tablets on 07/10/26 and 90 acetaminophen tablets on 07/20/26 when the facility's cycle started. -The pharmacy did not receive the FL-2 dated 07/21/26. -If the pharmacy received the new FL-2 dated 07/21/26, they would have compared the	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BLAKEY HALL	501 NORTH MANNING AVENUE ELON, NC 27244

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D 344	Continued From page 15 medications listed with the medications the pharmacy had entered. -If there was a discrepancy they would have call the Primary Care Provider (PCP) to clarify the order. Interview with the Resident Care Director (RCD) on 07/22/26 at 1:45pm revealed: -She sent all orders to the pharmacy by fax. -She would complete an FL-2 every 6 months in place of the 6 months signed physician orders. -She would print the orders from the computer and attach the orders to the FL-2. -She would have the PCP sign and date the FL-2. -She printed the orders that were attached to the FL-2 about a week before the FL-2 was signed. -She printed the orders for Resident #5 on 07/09/26 but did not have the PCP sign the orders until 07/21/26. -She did not realize the order written on 07/09/26 for the acetaminophen 500mg every 8 hours was not on the orders she printed to attach to the FL-2. Interview with the Administrator on 07/22/26 at 3:35pm revealed the RCD was efficient and he was confident in the RCD and her abilities.	D 344		

BLAKEY HALL RETIREMENT COMMUNITY

Plan of Correction for Statement of Deficiencies dated 8/4/26

Facility License: HAL001023
Licensed Capacity: 72 Beds
Administrator: James E. Weeks
Administrator License: A00001145

Facility Statement

Blakey Hall Retirement Community is a 72-bed licensed adult care home consisting of a 56-bed assisted living building and a separate, freestanding 16-bed Special Care Unit (SCU) located adjacent to the main assisted living building on the same property and operating under the facility's license.

Blakey Hall Retirement Community appreciates the time and professionalism demonstrated by the State survey team during the recent survey. The facility also appreciates the survey team's observations, guidance, and words of encouragement regarding the community and the care and environment provided to its residents. Blakey Hall takes great pride in its community, and the management team views the survey process as an opportunity to identify areas where established practices can be strengthened and improved.

Upon completion of the survey, the Executive Director and appropriate department directors met to review each finding. Corrective measures were implemented immediately where indicated, and additional monitoring procedures were established to support continued compliance.

D195 – 10A NCAC 13F .0608(c)-(f)

Staffing / Food Service Duties

Blakey Hall's freestanding SCU has a licensed capacity of 16 residents. Historically, familiar SCU care staff assisted with portions of the meal service process based on dementia-care guidance and resident-centered principles emphasizing familiarity, consistency, and limiting unnecessary changes within the environment of residents living with Alzheimer's disease and other forms of dementia.

This practice was intended to reduce resident anxiety and confusion and allow residents to receive assistance from staff members they knew and recognized. The practice had been in place for many years and had not previously been identified as a concern during a State survey.

Once the concern regarding the separation of direct-care and routine food-service responsibilities was identified, the facility immediately reviewed the process. Following the survey exit conference, the Executive Director met with Care Director [redacted] SCU

Director [redacted], and Dietary Director [redacted] and established a revised meal service process.

The revised process was implemented immediately. Dietary personnel are now responsible for routine food-service functions within the SCU, including meal setup, plating, routine meal-service functions, dishes, and meal-related cleanup. PCAs and MAs remain focused on resident care and supervision while continuing to provide individualized feeding assistance and assistance with plates, trays, and beverages as permitted by applicable 10A NCAC 13F requirements.

Appropriate staff were educated regarding the revised procedure and their respective responsibilities. The Executive Director and/or designee will monitor SCU meal service to verify that the revised process is followed and direct-care staff remain available for resident personal care, supervision, and individualized feeding-assistance needs.

Blakey Hall will continue to maintain the familiar, resident-centered environment that is important to its memory-care residents while ensuring compliance with applicable requirements.

Responsible Persons: Executive Director; Care Director [redacted]; SCU Director [redacted]; Dietary Director [redacted]
Corrective Action: Implemented immediately following the survey exit conference. 07/23/26

D296 – 10A NCAC 13F .0904(c)(7)

Nutrition and Food Service – Therapeutic Menus

The facility reviewed the finding concerning matching therapeutic menus for residents with physician-ordered therapeutic diets. At the time of the survey, dietary staff were providing dietary modifications based upon their understanding of residents' physician-ordered diets; however, the corresponding written therapeutic menus were not posted and available for staff guidance.

Upon identification of the concern, Dietary Director [redacted] immediately reviewed the physician-ordered therapeutic diets and obtained the appropriate matching menus for the Low Concentrated Sweets (LCS) and IDDSI Level 6 diets. The appropriate therapeutic menus were immediately posted and made available in the dietary department for staff reference and guidance.

Dietary staff were educated regarding the requirement to utilize the appropriate therapeutic menu when preparing and serving meals for residents with physician-ordered therapeutic diets rather than relying solely upon customary practices or individual staff knowledge.

Going forward, the Dietary Director will review new and changed physician diet orders to ensure the corresponding therapeutic menu is available and accessible to dietary staff. The Dietary Director and/or Executive Director will audit current therapeutic diet orders against available therapeutic menus weekly for four weeks and monthly for three months thereafter.

Any discrepancy identified will be corrected immediately. with additional staff education provided when necessary.

Responsible Persons: Executive Director and Dietary Director [redacted]
Corrective Action: Implemented immediately upon identification of the survey concern. 07/23/26

D312 – 10A NCAC 13F .0904(f)(2)

Individual Feeding Assistance

The facility reviewed the finding regarding feeding assistance within the 16-bed SCU as part of the same management review and corrective process associated with D195.

Immediately following the survey, the Executive Director met with Care Director [redacted] SCU Director [redacted], and Dietary Director [redacted] to review the overall SCU meal service process. The facility's historical process was designed around maintaining familiarity and consistency for residents living with dementia. The survey findings provided an opportunity to evaluate how the process could be revised so direct-care staff could remain more consistently focused on residents requiring feeding assistance.

The corrective action implemented for D195 is therefore also an important component of the facility's corrective action for D312. Dietary personnel are now responsible for routine food-service duties, including plating and other dietary responsibilities that could previously interrupt a PCA or MA who was providing resident assistance.

The facility also reviewed the current feeding-assistance needs of SCU residents. Staff were educated that residents requiring assistance with eating are to receive assistance upon receipt of their meals and that assistance is to be provided in an unhurried manner that maintains each resident's dignity and respect. Appropriate hand hygiene and glove practices during meal assistance were also reviewed with staff.

Management will continue to evaluate the number and needs of residents requiring feeding assistance and ensure appropriate staff coverage is available during meals. Additional trained facility staff will assist during meal periods when needed based upon residents' current needs.

The SCU Director, Care Director, Executive Director, and/or designee will observe meal service weekly for four weeks and monthly for three months thereafter. Any concerns identified will be addressed immediately through education, adjustment of meal coverage, or other corrective action as appropriate.

Responsible Persons: Executive Director; Care Director [redacted] SCU Director [redacted]; Dietary Director [redacted]
Corrective Action: Implemented immediately following the survey exit conference as part of the facility's overall SCU meal-service corrective action.
07/23/26

D344 – 10A NCAC 13F .1002(a)

Medication Orders

The facility reviewed the circumstances involving the medication order identified for Resident #5. Resident #5 had a signed physician's order dated 07/09/26 for acetaminophen 500 mg every eight hours for right shoulder pain. The medication was entered on the eMAR and was being administered according to the physician's order. The discrepancy identified was that this order was not reflected on the subsequently signed FL-2 dated 07/21/26.

The facility's review determined that two processes occurred within the same time period. The resident's existing medication orders had been printed in preparation for physician review and signature of the updated FL-2. During that process, an additional acetaminophen order was obtained from resident's Hospice provider. Because the medication list had already been printed for physician review, the newer order was not reflected on the subsequently completed FL-2.

Blakey Hall had an established process for handling new medication orders and completing FL-2s. However, this occurrence identified an opportunity to strengthen that process when a new or changed medication order is received between the time an FL-2 medication list is prepared and the time the completed FL-2 is signed.

Immediately upon identification of the discrepancy, the Executive Director reviewed the situation with Care Director [redacted] and SCU Director [redacted]. An additional final reconciliation step was added requiring review of the current eMAR and any new or changed physician orders before an FL-2 is considered complete.

The facility also added its contracted pharmacy as an additional level of professional review. Updated FL-2s and applicable medication orders will be forwarded to the pharmacy for comparison against the resident's current pharmacy medication profile. Any discrepancy identified by facility staff or the pharmacy will be promptly clarified with the prescribing practitioner, with the clarification documented in the resident's record.

This additional safeguard provides another professional set of eyes and reduces the opportunity for timing or human error to result in a discrepancy among the resident's current medication orders, eMAR, FL-2, and pharmacy profile.

The revised process was implemented immediately upon identification of the concern. The Executive Director, Care Director, and SCU Director will monitor the process and audit completed FL-2s against current medication orders and the eMAR. Any discrepancy will be addressed immediately and the process reviewed to determine whether additional corrective measures are indicated.

Responsible Persons: Executive Director; Care Director [redacted]; SCU Director [redacted]

Corrective Action: Implemented immediately upon identification of the discrepancy. 07/23/26

Administrator Certification

The corrective actions described above have been reviewed with the appropriate members of the Blakey Hall Retirement Community management team. The facility will continue to monitor these areas and make adjustments when necessary to maintain compliance and provide quality, respectful, resident-centered care.

Administrator / Executive Director: James E. Weeks

Administrator License Number: A00001145

Signature: James E Weeks **Date:** 8/24/2026