STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065036	A. BUILDING: _____ B. WING _____	R-C 08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HANOVER HOUSE	3915 STEDWICK COURT WILMINGTON, NC 28412

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D 000	Initial Comments The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted a follow-up survey and complaint investigation on 08/18/26 - 08/20/26.	D 000		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (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	D 259		

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D 259	Continued From page 1 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 observations, interviews, and record reviews, the facility failed to ensure resident care plans were complete and included the required information for 5 of 5 sampled residents (#1, #2, #3, #4, #5) related to not including information for hearing aids (#4, #5) and failing to have the name and dated signature of the assessor upon completion of the care plans (#1, #2, #3, #4, #5). The findings are: 1. Review of Resident #4's current FL-2 dated 07/30/26 revealed diagnoses included dementia, hypertension, depression, and osteoporosis. Review of Resident #4's Resident Register revealed: -Resident #4 was admitted to the facility on 09/08/25. -Hearing aids were checked in the section for special aids. Review of Resident #4's Care Plan dated 01/28/26 revealed: -The hearing section was marked as adequate for daily activities. -The primary care provider (PCP) signed the care plan on 01/29/26.	D 259		

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D 259	Continued From page 2 -The section for the assessor's name, signature, and the date was blank. Review of Resident #4's Care Plan dated 02/27/26 revealed: -The hearing section was marked as adequate for daily activities. -The PCP signed the care plan on 03/03/26. -The section for the assessor's name, signature, and the date was blank. Review of Resident #4's Significant Change Care Plan dated 06/25/26 revealed: -The hearing section was marked as adequate for daily activities and hearing aids for both ears. -The PCP signed the care plan on 06/29/26. -The section for the assessor's name, signature, and the date was blank. Interview with the Administrator on 08/19/26 at 2:46pm revealed: -She completed Resident #4's care plan dated 06/25/26. -She documented Resident #4's care plan was a significant change. -The facility was going to document that Resident #4's hearing aids were placed in her ears and removed at night. -She sent Resident #4's care plan to her PCP in June 2026 to sign. Second interview with the Administrator on 08/20/26 at 5:57pm revealed: -Resident #4's care plans should have listed that the resident had hearing aids. -Resident #4's care plans should have indicated that the resident needed help with her hearing aids. Refer to interview with the Administrator on	D 259		

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D 259	Continued From page 3 08/20/26 at 5:57pm. 2. Review of Resident #3's current FL-2 dated 07/28/26 revealed diagnoses included chronic respiratory failure, dementia, and chronic pain. Review of Resident #3's Resident Register revealed Resident # 3 was admitted to the facility on 01/06/26. Review of Resident #3's Care Plan dated 01/26/26 revealed: -The primary care provider (PCP) signed the care plan on 01/26/26. -The section for the assessor's name, signature, and the date was blank. Refer to interview with the Administrator on 08/20/26 at 5:57pm. 3. Review of Resident #5's current FL-2 dated 06/29/26 revealed diagnoses included diabetes mellitus type 2, chronic obstructive pulmonary disease, hyperlipidemia, benign prostatic hyperplasia, muscle weakness, and abnormalities of gait and mobility. Review of Resident #5's Resident Register revealed: -The resident was admitted to the facility on 09/09/24. -Hearing aids were not checked off in the section for special aids. Observation of Resident #5's room on 08/20/26 at 1:15pm revealed: -The resident was sitting in a chair beside a small table. -There were hearing aids in a portable charger box plugged in with a light displayed on the	D 259		

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D 259	Continued From page 4 charger box on the small table. Interview with Resident #5 on 08/20/26 at 1:15pm revealed: -He had hearing aids since he was admitted to the facility. -His hearing aids were currently charging. -He could put the hearing aids in himself and charge them without assistance. -He usually wore his hearing aids at night. -He did not like to wear his hearing aids when he left his room because they irritated his ears and caused headaches. Review of Resident #5's current Care Plan dated 02/06/26 revealed: -The resident required limited assistance by staff with bathing and was independent with all other activities of daily living (ADLs). -The resident was documented as being oriented and his memory was adequate. -The resident's hearing was documented as being adequate for daily activities. -The block for "uses hearing aids" was not checked off and there were no comments to indicate if the resident needed assistance with hearing aids. -Resident #5's primary care provider (PCP) signed and dated the resident's care plan on 02/06/26. -The section for the assessor's name, signature, and date was blank. Interview with the Administrator on 08/20/26 at 5:57pm revealed: -She was not aware Resident #5 used hearing aids. -Resident #5's care plan should have been checked off in the box beside hearing aids and documented if he needed assistance with the	D 259		

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D 259	Continued From page 5 hearing aids. Refer to interview with the Administrator on 08/20/26 at 5:57pm. 4. Review of Resident #1's current FL-2 dated 07/27/26 revealed diagnoses included unspecified dementia, mixed hyperlipidemia, paroxysmal atrial fibrillation, osteoarthritis, and vascular syndromes of the brain. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 04/13/26. Review of Resident #1's current Care Plan dated 05/07/26 revealed: -The resident was documented as sometimes disoriented, forgetful, and needed reminders. -The resident required supervision by staff for eating. -The resident required limited assistance by staff with toileting, ambulation, dressing, grooming, and transferring. -The resident required extensive assistance by staff with bathing. -Resident #1's primary care provider (PCP) signed and dated the resident's care plan on 05/07/26. -The section for the assessor's name, signature, and date was blank. Refer to interview with the Administrator on 08/20/26 at 5:57pm. 5. Review of Resident #'2's current FL-2 dated 07/27/26 revealed: -Diagnoses included hypertension, dementia, hyperlipidemia, depression, osteoporosis, and chronic obstructive pulmonary disease.	D 259		

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-Resident #2 was intermittently disoriented.
-Resident #2 was continent of bowel and incontinent of bladder.
-Resident #2 required assistance with bathing and dressing.
-Resident #2's recommended level of care was memory care.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 04/01/26.

Review of Resident #'2 Care Plan revealed:
-The assessment date was 01/26/26.
-Resident #2 used a walker to assist with ambulation/locomotion.
-Resident #2 used oxygen (nasal cannula, concentrator, and portable oxygen tank).
-Resident #2's bowels and bladder were normal.
-Resident #2 was oriented and the resident's memory was adequate.
-Resident #2 required limited assistance with bathing.
-Resident #2 required supervision with dressing.
-Resident #2's primary care provider (PCP) signed and dated the care plan on 01/26/26.
-The section for the assessor's name, signature, and date was blank.

Interview with Resident #2 on 08/20/26 at 8:09am revealed staff assisted her with bathing and dressing.

Refer to interview with the Administrator on 08/20/26 at 5:57pm.

_____

Interview with the Administrator on 08/20/26 at 5:57pm revealed:
-She or the Resident Care Coordinator (RCC) and the Special Care Coordinator (SCC) were

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D 259	Continued From page 7 responsible for completing resident assessments and care plans. -She had not noticed and did not realize there was a place for the assessor to date and sign resident care plans.	D 259		
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 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure all food items stored by the facility were protected from contamination related to temperatures of the walk-in cooler and freezer and improper storage of items in the freezer that were not to be frozen and items that sat out at room temperature that required refrigeration after opening. The findings are: Review of the facility's census report on 08/18/26 revealed there were 56 residents in the facility.	D 283		

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D 283	Continued From page 8 Review of the facility's current Environmental Inspection Report for the kitchen dated 07/30/26 revealed: -The facility received 4.5 demerits. -The threshold to the walk-in freezer was in poor repair. Observations of the kitchen on 08/18/26 from 9:30am to 12:15pm revealed: -The Lead Cook was observed cutting up two heads of cabbage. -The walk-in cooler was empty. -On the prep table was 1 jar of opened grape jelly which indicated to refrigerate after opening. -On the prep table was 1 opened bottle of yellow mustard that indicated to refrigerate after opening. -On the prep table was a large metal bowl half filled with ice that contained 1 gallon of milk and 12 sandwich bags filled with a ½ turkey and cheese sandwich in each bag. -On the prep table was 1 unopened pack of turkey and an opened pack of turkey. Observation of the walk-in cooler on 08/18/26 at 2:49pm revealed: -An opened bottle of yellow mustard and an opened jar of grape jelly were on the right side of the cooler on the second shelf. -A metal bowl with 12 sandwich bags that contained a ½ turkey and cheese sandwich in each bag was on the right side of the cooler on the third shelf. -The metal bowl did not have any milk or ice in the bowl. Observations of the kitchen on 08/18/26 from 9:30am to 5:26pm revealed: -On the lower shelf of a prep table on the left side of the warming table was 1 opened container of	D 283		

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barbeque sauce and 1 opened container of Italian dressing that indicated refrigerate after opening.
-On the lower shelf of a prep table on the right side of the warming table was a 50 pound (lb) box of red potatoes and 125 count box of apples which indicated keep refrigerated.
-On the prep area to the left side of the sink was a ½ filled 50 lb box of potatoes that indicated keep refrigerated and a mesh bag with 5 heads of cabbage with outer leaves showing dark/black discoloration and scattered black spots.

Observation of the walk-in freezer on 08/18/26 from 9:50am to 5:26pm revealed:
-There were 13- 46 ounce (oz) containers of thickened liquids in the walk-in freezer with storage and handling that indicated store at room temperature and do not freeze.
-There was 1- 46 oz container of thickened liquid in 1 of 2 chest freezers with storage and handling that indicated store at room temperature and do not freeze.
-There were 44- 32 oz containers of scrambled egg mix in the walk-in freezer that indicated do not freeze and to always store egg products under refrigeration 33°F (degrees Fahrenheit) - 40°F.
-There were 8- 14 oz cans of whipped topping that indicated do not freeze and to keep refrigerated 33°F - 40°F.

Observations of 2 chest size freezers in the kitchen on 08/18/26 from 9:50am to 5:26pm revealed:
-There were no temperature logs for either freezer.
-Neither freezer had a thermometer to measure temperature.

Observations of the walk-in freezer on 08/18/26

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and 08/19/26 revealed:
-On 08/18/26 at 2:59pm, the temperature was 26°F.
-On 08/18/26 at 5:53pm, the temperature was 32°F.
-On 08/19/26 at 8:03am, the temperature was 24°F.
-On 08/19/26 at 11:41am, the temperature was 10°F.

Review of the July 2026 temperature log for the walk-in cooler revealed:
-The log contained columns for the day/date, temperature, and initials for the temperature to be taken first shift and second shift.
-The temperature was taken 31 of 31 opportunities during first shift.
-The temperature range during first shift ranged from 25°F-40°F, which was taken by a dietary cook.
-The log was completed 28 of 31 opportunities during second shift.
-The temperature range during second shift was 26°F -42°F.
-The temperature was not taken on 07/03/26, 07/19/26, and 07/31/26 during second shift.
-On 07/28/26-07/29/26, the temperature was 42°F taken by a dietary cook and dietary aide.

Observation of the August 2026 temperature log for the walk-in cooler revealed:
-The log contained columns for the day/date, temperature, and initials for the temperature to be taken first shift and second shift.
-The temperature was taken 13 of 18 opportunities during first shift.
-The temperature was not taken on 08/06/26 during first shift.
-On 08/15/26-08/18/26 a solid line was drawn through the column for temperature and initial for

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first shift.
-The temperature range for first shift was 31°F to 55°F.
-The temperature was recorded at 40°F on 08/07/26-08/11/26 by the Administrator 4 of those 5 days during first shift.
-The temperature was recorded at 55°F during first shift by the Lead Cook
-The temperature was taken 13 of 18 opportunities during second shift.
-The temperature was not taken on 08/04/26 during second shift.
-On 08/15/26-08/18/26 a solid line was drawn through the column for temperature and initial for second shift.
-The temperature range during second shift was 30°F to 65°F.
-The temperature was recorded at 65°F on 08/06/26 by a dietary cook during second shift.
-The temperature was recorded at 40°F on 08/09/26-08/11/26 by the Administrator during second shift.
-The temperature was recorded at 60°F on 08/14/26 by the Lead Cook during second shift.
-Handwritten outside the column for second shift on 08/13/26 was 55°F at 4:00pm.

Review of the July 2026 temperature log for the walk-in freezer revealed:
-The log contained columns for the day/date, temperature, and initials for the temperature to be taken first shift and second shift.
-The temperature was taken 31 of 31 opportunities during first shift.
-The temperature was greater than 0°F during first shift on 7 of 31 opportunities with temperatures ranging from 2°F to 21°F.
-The temperature was recorded at 3°F on 07/02/26 by a dietary aide during first shift.
-The temperature was recorded at 19°F on

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D 283	Continued From page 12 07/07/26 by a dietary aide during first shift. -The temperature was recorded at 21°F on 07/08/26 by the Administrator during first shift. -The temperature was recorded at 2°F on 07/10/26 by the Lead Cook during first shift. -The temperature was recorded at 8°F on 07/11/26 by a dietary aide during first shift. -The temperature was recorded at 2°F on 07/23/26 by a dietary aide during first shift. -The temperature was recorded at 19°F on 07/28/26 by the dietary cook during first shift. -The temperature was taken 27 of 31 opportunities during second shift. -The temperature was greater than 0°F during second shift 9 of 31 opportunities with temperatures ranging from 3°F to 20°F. -The temperature was not taken on 07/03/26 during second shift. -The temperature was recorded at 3°F on 07/07/26 by a dietary aide during second shift. -The temperature was recorded at 20°F on 07/08/26 by the dietary cook during second shift. -The temperature was recorded at 10°F on 07/09/26 by the Lead Cook during second shift. -The temperature was recorded at 5°F on 07/10/26 by the Lead Cook during second shift. -The temperature was recorded at 9°F on 07/11/26 by a dietary aide during second shift. -The temperature was recorded at 3°F on 07/20/26 by the Lead Cook during second shift. -The temperature was not taken on 07/21/26 during second shift. -The temperature was recorded at 10°F on 07/22/26 by the Lead Cook during second shift. -The temperature was not taken on 07/23/26 during second shift. -The temperature was recorded at 10°F on 07/24/26 by the Lead Cook during second shift. -The temperature was not taken on 07/31/26 during second shift.	D 283		

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D 283	Continued From page 13 Review of the August 2026 temperature log for the walk-in freezer revealed: -The log contained columns for the day/date, temperature, and initials for the temperature to be taken first shift and second shift. -The log had been completed 18 of 18 opportunities during first shift. -The temperature was greater than 0°F during first shift 6 of 18 opportunities with temperatures ranging from 8°F to 20°F. -The temperature was recorded at 8°F on 08/12/26 by the dietary cook during first shift. -The temperature was recorded at 10°F on 08/14/26 by the Lead Cook during first shift. -The temperature was recorded at 20°F on 08/15/26 by the Lead Cook during first shift. -The temperature was recorded at 15°F on 08/16/26 by the Lead Cook during first shift. -The temperature was recorded at 10°F on 08/17/26 by the Lead Cook during first shift. -The temperature was recorded at 15°F on 08/18/26 by the Lead Cook during first shift. Review of an email from the facility's outside refrigeration vendor revealed: -On 08/10/26, the refrigeration repair company received a text message from the facility's Regional Maintenance Director (RMD) that indicated the walk in cooler was getting warm and was already at 52 degrees. -On 08/10/26, a technician went to the facility and found the unit was frozen and found the root cause was a completely stopped up drain line. The drain line was cleaned, which started the system up. It was noted that the units thermostat was set too low and the shut off temperature was adjusted to 36 degrees. -On 08/11/26, the RMD texted the refrigeration repair company to see if someone was able to get	D 283		

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things back up and running, as he had not been able to reach the Administrator.
-On 08/13/26, the refrigeration repair company received a text from the RMD that the walk in cooler was back up to 55 degrees and wanted to know if a technician was available to go to the facility that day or on 08/14/26.
-On 08/13/26, the refrigeration repair company informed the RMD they would have someone out to the facility the morning of 08/14/26.
-On 08/14/26, the RMD texted the refrigeration repair company to let them know no one had been to the facility and the cooler temperature was in the 60s.
-On 08/15/26, the RMD texted the refrigeration repair company to let them know that no one had come to the facility and the cooler was down and the freezer was up to 20 degrees.
-On 08/17/26, the refrigeration repair company texted the RMD and informed him a technician would be at the facility that morning. The RMD indicated the walk-in freezer temperature had been climbing and both (walk-in cooler and freezer) needed to be checked.

Interview with the Lead Cook on 08/18/26 at 08/18/26 at 10:51am, 11:05am, and 3:08pm revealed:
-She worked at the facility for about 6 months.
-When she took the temperature for the walk-in cooler on 08/14/26 during first shift, the temperature was at 55°F, at which time she informed the Administrator.
-The Administrator instructed staff to move things from the cooler to the freezer.
-Items moved from the cooler to the walk-in freezer were things like juice, liquid eggs, milk, thickened liquids, butter, and cheese.
-She recalled things such as salad, coleslaw, and squash being thrown away from the cooler.

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D 283	Continued From page 15 -She did not know if anyone came out to check the cooler on 08/14/26. -The cabbage she cut up earlier that morning had leaves that were discolored with black spots. -When items were moved from the walk-in cooler to the walk-in freezer on 08/14/26 she did not read labels to see if those items could be frozen, as she just put things in the freezer that she thought could be frozen. -Two chest freezers had been brought in and put into the kitchen over the previous weekend. -She was not aware the there were no temperature logs for the two chest freezer or that they did not have thermometers to measure the temperature. -All dietary staff were responsible for taking the temperature of the walk-in cooler and freezer two times a day. -The Administrator would check the temperatures at times for the walk-in cooler and freezer. -Each line on the thermometer between the numbers looked like 5°F, as she did not know each line between the numbers represented 2°F. -She did not know what the temperature of the walk-in cooler or freezer needed to be. -She did not know what temperature would be cause for concern for the walk-in cooler or freezer. -She would notify the Administrator if she thought the temperature was high or if the walk-in cooler or freezer felt warm. Interview with a dietary aide on 08/18/26 at 3:17pm revealed: -She worked 3-4 days a week at the facility. -Any kitchen staff could check the temperature for the walk-in cooler and freezer. -She was not sure how many times a day the temperature for the walk-in cooler and freezer were checked.	D 283		

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D 283	Continued From page 16 -She was not aware what the temperature of the walk-in cooler or freezer had to be. -She could not recall if she had ever checked the temperature of the walk-in cooler or freezer. Interview with the Maintenance Director on 08/20/26 at 11:29am revealed: -The RMD called him on 08/14/26 and asked him to go to the facility and check the walk-in cooler. -He did not check the temperature of the walk-in cooler but found the cooler to be hot. -He was able to get the fan inside the walk-in cooler to work after he noticed the breaker had tripped. -After fixing the fan, the temperature never went down and the cooler was not getting cooler. -He called the RMD to let him know he could not fix the cooler and the temperature was not getting cooler. -The RMD indicated that he would call the repair company. -He did not know when the repair company was called but they came out to facility on 08/17/26. -He had no prior knowledge prior to 08/14/26 of any issues with the walk-in cooler and learned a few days prior the walk-in freezer temperature was warm and not holding temperature. -He did not know what the temperature of the walk-in cooler and freezer were supposed to be. -He knew green on the thermometer was good and anything in the red was a concern. Interview with the RMD on 08/20/26 at 12:57pm revealed: -The Administrator called him the morning of 08/10/26 and indicated that cooler temperature was 40°F. -He called the refrigeration vendor and they came out to the facility on 08/10/26. -He received a call from the Administrator on	D 283		

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D 283	Continued From page 17 08/13/26 at 4:30pm that the walk-in cooler had gotten hot. -He asked the Administrator about the temperature log and she indicated that the temperature had gone up to around 50°F, which was not common to go up that much within a couple of hours. -The refrigeration vendor was not able to send a technician to the facility on 08/13/26, but a technician came out on 08/14/26. -Kitchen staff were to check the temperature of the walk-in cooler and freezer 3 times a day (breakfast, lunch, and dinner), which had recently changed from 2 times a day (breakfast and dinner). -Staff would wait to report any issues at the end of the day. -On 08/13/26, the Administrator called him at 4:30pm. -Waiting to the end of the day to call him made it hard to get a vendor to come out that same day. -He tried to come to the facility once a week but sometimes it would be about once every two weeks. -When he came to the facility he would do a spot check of the temperature logs and he would check them when he came to deal with an issue. -The walk-in cooler should be around 36°F plus or minus a couple of degrees. -The walk-in freezer should be around 0°F, plus or minus 5 to 10 degrees. -He would be concerned if the walk-in cooler went days at a temperature of 40°F to 50°F, as there could be an issue with freon being low, an electrical issue, dirty coils, or a drainage issue, which would cause the food to go bad. -He would be concerned if the walk-in freezer temperature was in the high teens or low 20s because at those temperatures, the freezer would not be freezing items properly.	D 283		

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D 283	Continued From page 18 Telephone interview with the Regional Vice President of Operations (RVPO) on 08/19/26 at 12:25pm revealed: -He received at text message from the RMD on 08/15/26 at 8:20am that indicated the walk-in cooler temperature was not going down and the walk-in freezer temperature was changing and getting warmer. -The RMD immediately called the repair company on 08/15/26, but they did not come to the facility until 08/17/26 and again on 08/18/26. -He did not talk to the RMD after their text communication on 08/15/26, because the RMD had the situation under control. -Due to the issue with walk-in cooler and freezer, the RMD took 2 chest freezers to the facility on 08/15/26 to be used in the interim. -There was a coolant issue with the walk-in cooler and a valve malfunctioned on the walk-in freezer. -On 08/14/26 during an Administrator meeting, he instructed the Administrator the temperature logs for the walk-in cooler and freezer were being increased to monitoring 3 times daily from the 2 times daily. -The kitchen staff and kitchen manager were to monitor the logs, but the Administrator was ultimately responsible for ensuring the walk-in cooler and freezer were being monitored and logs were completed. -The walk-in cooler should be around 30°F, plus or minus 5 degrees and the freezer should be around 0°F. -If the temperatures of the walk-in cooler or freezer were out of range, he expected staff to notify the Administrator. -The Administrator was responsible for notifying the RMD, who would then notify him. -He could not recall if he had been notified about the temperature logs and temperatures being out	D 283		

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of range, as he did not start his position until around 07/21/26.
-He could not remember all the calls he received because he received about 50-60 calls daily.
-He was not aware until the evening of 08/18/26 that items had been frozen that should not have been frozen such as the eggs.
-He was not aware that the thickened liquids and can whipped cream had been frozen when they should not have been frozen.
-He was concerned about the canned whipped cream being frozen because it was compressed air which could expand and explode if frozen.
-He would expect staff to read the labels on items to see if they could be frozen, as he would be concerned that things were frozen that should not have been frozen according to the label.

Second interview with the RVPO on 08/20/26 at 2:08pm revealed:
-He was not aware of any concerns with the walk-in cooler or freezer prior to getting a text message from the RMD on 08/15/26, as he did not know a vendor had been contacted on 08/10/26.
-The RMD would typically troubleshoot any equipment issues and was responsible for contacting vendor for repairs in the facility.
-He would expect the RMD to notify him of issues but knew the RMD would handle any issues.
-He expected the Administrator to monitor the temperature logs daily and to monitor to see if the temperature was off 5 to 10 degrees, and then he would expect the Administrator to notify him and the RMD.

Interview with the refrigeration technician on 08/18/26 at 2:51pm revealed:
-He came to the facility on 08/18/26 to fix the walk-in cooler.

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-While he was at facility, he noticed the walk-in freezer was not holding temperature.
-The facility had already put in a call about the freezer on 08/17/26.
-The walk-in cooler temperature should be around 35°F to 38°F.
-The walk-in freezer temperature should be around 0°F to -5°F.

Telephone interview with the Environment Health Services Manager on 08/19/26 at 3:09pm revealed:
-The temperature for the walk-in cooler needed to be at 41°F or less.
-The temperature of the walk-in freezer needed to be at -10°F to 0°F.
-She would expect food to be thrown away if the cooler temperature was above 41°F, which could cause risk for foodborne illnesses.

Telephone interview with the facility's primary care provider (PCP) on 08/19/26 at 10:41am revealed:
-She was not aware the facility had issues with the walk-in cooler and freezer not holding proper temperatures.
-It would be concerning if perishable foods were not stored appropriately, as the food could go bad and cause an infection.
-Depending on the severity of the infection, the symptoms could be things like diarrhea, nausea, vomiting, and/or fever.

Interview with the Administrator on 08/19/26 at 10:58am revealed the facility did not have a policy regarding food storage.

Second interview with the Administrator on 08/18/26 at 3:35pm revealed:
-One of the kitchen staff notified her on 08/14/26 that the walk-in cooler was not working properly

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and that the temperature was 58°F, as the temperature should have been below 32°F.
-The refrigeration repair company came out on 08/14/26 and fixed the fan in the walk-in cooler.
-There were no issues with the walk-in cooler over the previous weekend (08/15/26 - 08/16/26).
-The refrigeration repair company came back to the facility on 08/17/26 as the temperature in the walk-in cooler was going up again, but she could not recall what the temperature was.
-She instructed staff on 08/14/26 to move what they could from the walk-in cooler to the freezer when the temperature was above 50°F, as some things in the cooler had to be thrown away.
-The RMD came to the facility on 08/15/26 at which time the walk-in freezer had a temperature of 18°F.
-She called the RMD on 08/16/26 after she got a text on 08/16/26 that the walk-in freezer temperature was high but did not recall what the temperature was.
-She came to the facility and saw the latch to the walk-in freezer was not allowing the door to close properly.
-Any kitchen staff were able to check the temperature of the walk-in cooler and freezer, which was to be checked two times a day.
-She was not aware staff put items in the freezer that could not be frozen, such as the eggs, thickened liquids, or whipped cream.
-She did not instruct staff to read labels to determine what could be frozen when they moved items from the cooler to the freezer.
-She did not check the freezer after staff had moved things from the cooler.
-The temperature for the walk-in cooler should be at 32°F or below.
-The temperature for the walk-in freezer should range from -5°F to 0°F.
-She would be concerned if food had been used

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D 283	Continued From page 22 that had been sitting out at room temperature for multiple hours, because there would be a risk of the food spoiling due to the heat and humidity. Third interview with the Administrator on 08/20/26 at 5:57pm revealed: -The cook told her on 08/10/26 the walk-in cooler's temperature was high, but she did not recall what the temperature was. -Kitchen staff were checking the temperature for the walk-in cooler and freezer 2 times a day (breakfast and lunch), but it was increased to be checked 3 times a day (breakfast, lunch, and dinner) by the RVPO on 08/18/26. -She looked at the temperature logs when she came to work in the mornings but she did not look at them every day. -Staff would notify her when they noticed a temperature change. -She never gave staff a temperature number for concern as to when she should be notified. -Anytime the thermometer was in the red it would be considered a danger zone and she should be notified. _____ The facility failed to ensure all residents were protected from foodborne illnesses related to open food items which sat out at room temperature that required refrigeration after opening. The temperature of the walk-in cooler should be 41°F or less and the temperature of the walk-in freezer should be -10°F to 0°F. The temperature of the walk-in cooler was greater than 41°F on at least 5 occasions in July and August 2026 with a temperature recorded as high as 65°F. The temperature of the walk-in freezer was less than -10°F to 0°F on at least 41 occasions in July and August 2026 with a temperature as high as 20°F. The facility's failure to ensure food was stored properly and at	D 283		

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D 283	Continued From page 23 adequate temperatures increased the risk of illness to residents, which could cause diarrhea, nausea, vomiting, and fever. The facility's 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 283		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure snacks were listed on the facility's menu. The findings are: Review of the facility's census report dated 08/18/26 revealed there were 56 residents in the facility. Observation on 08/18/26 at 9:30am of a dry erase board outside the entrance to the dining room	D 298		

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D 298	Continued From page 24 revealed: -There were three handwritten columns for breakfast, lunch, and dinner that listed what was being served at each meal. -There was no information related to snacks. Observation on 08/19/26 at 7:45am of a dry erase board outside the entrance to the dining room revealed: -There were three handwritten columns for breakfast, lunch, and dinner that listed what was being served at each meal. -In the lower right corner of the board, snack times of 10:00am, 2:00pm, and 8:00pm were handwritten. Review of the facility's diet extension menus dated 08/18/26, 08/19/26, and 08/20/26 revealed: -The meals listed were breakfast, lunch, and dinner. -There were columns for a regular/no added salt (NAS) diet, mechanical soft chopped diet, mechanical soft diet, pureed diet, and finger foods diet. -There was a column for serving which indicated the serving size to be served for each item on the menu that was to be served with each offered diet. -There was no column for snacks to be served for each offered diet. Observations of the kitchen on 08/18/26-08/20/26 revealed: -There were no chips or crackers. -There were 8 large cans of diced pears, 2 large can of pineapple slices, 1 large can of apples, 8 large cans of mandarin oranges. Observation of the business office on 08/19/26 at 3:00pm revealed:	D 298		

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D 298	Continued From page 25 -There were 8 unopened boxes of peanut butter crackers that had 8 packs of crackers in each box. -There was 1 unopened box of marshmallow pies containing a total of 12 pies. Interview with a dietary cook on 08/19/26 at 11:28am revealed: -She had worked in the kitchen for a few months. -The facility offered snacks at 10:00am, 2:00pm, and 8:00pm. -The facility's menu had never listed snacks as part of the menu. -The kitchen staff gave out snacks based on what was available from being ordered on the weekly food truck and what the Administrator would buy for snacks. -The facility mostly gave out crackers, chips, and sandwiches for snacks. -Other things served as snacks included vanilla wafer cookies, peanut butter crackers, fig cookies, oatmeal cakes, apples, and pudding. -For the pureed diets, she usually gave pudding or pureed fruit. -For the mechanical soft diets, she usually gave things such as canned apples, mandarin oranges, and soft cookies with milk. -Some snacks were kept in the business office. -She did not have a guide to use to serve snacks for the diets offered by the facility. Interview with the Business Office Manager (BOM) on 08/19/26 at 3:03pm revealed: -Snacks were given out three times a day, but he did not know the times. -The Administrator would go to local stores and buy snacks as well as ordering some that came on the weekly food truck. -Snacks were kept in the office to help monitor the snack supply.	D 298		

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D 298	Continued From page 26 -He had nothing to do with snacks. Interview with the Administrator on 08/20/26 at 5:57pm revealed: -The facility offered snacks and snacks were always available to the residents. -The therapeutic menu extension menu did not include snacks as part of the menu. -She was not aware that the therapeutic menu extension needed to include snacks.	D 298		
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 interviews and record reviews, the facility failed to ensure resident rights were maintained related to failure to keep residents' personal and medical records confidential for 2 of 2 sampled residents. The findings are: Review of the facility's policy on resident privacy, Health Insurance Portability and Accountability Act (HIPAA), and confidential information dated 04/01/25 revealed: -The facility protected and respected the confidentiality of their residents' protected health information (PHI) and followed the privacy and security requirements of the HIPAA, where applicable, as well as any state law requirements protecting resident privacy. -It was the facility's policy to ensure that the	D 338		

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operations, activities, and affairs of the facility and their residents and clients were kept confidential to the greatest possible extent.

Review of the facility's Resident Agreement Section VI Miscellaneous D. PHI and Confidentiality addendum dated 06/01/25 revealed:
-The facility respected the privacy of the residents' personal information and PHI and was committed to maintaining such information secure and confidential.
-The facility would protect the residents' personal information and PHI and implement measures to prevent the improper dissemination of such information in compliance with applicable federal and state laws.

Review of Resident #4's current FL-2 dated 07/30/26 revealed diagnoses included dementia, hypertension, depression, and osteoporosis.

a. Review of Resident #6's current FL-2 dated 07/30/26 revealed diagnoses included diabetes chronic pain, and muscle weakness.

Review of an electronic mail (email) and attachment sent from the facility's Administrator to Resident #4's responsible person dated 08/07/26 at 9:01am revealed:
-The email stated there was an attached letter.
-The document attached contained Resident #6's physician order review.
-Resident #6's name, date of birth, allergies, diagnoses, primary care provider (PCP), name of pharmacy, and a list of Resident #6's medications were listed on the physician order review.
-On the first page of Resident #6's physician order review, there was a handwritten note that Resident #6 had frequent visits to the emergency

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department.
-Resident #6's August 2026 electronic medication administration record (eMAR) was also included in the attachment.
-Resident #6's name, date of birth, room number, PCP, allergies, diagnoses, name of pharmacy, diet, a list of Resident #6's medications, and indication for medication usage were listed on the eMAR.

Telephone interview with Resident #4's responsible person on 08/18/26 at 4:05pm revealed:
-She received an email from the Administrator with an attachment on 08/07/26.
-The attachment contained another resident's personal and medical documents.
-No one from the facility had tried to contact her related to receiving another resident's personal and medical documents.

Interview with the Administrator on 08/18/26 at 3:47pm revealed:
-If she sent an email and attached the wrong document that contained another resident's information she would contact the person it was sent to and ask them to disregard.
-She attached Resident #6's documents to an email she sent to Resident #4's responsible person on 08/07/26.
-She attempted to contact Resident #4's responsible person on 08/07/26 and she did not answer and she did not leave a voice mail.
-She did not make any other attempts to reach Resident #4's responsible person.
-She did not know that she needed to notify Resident #6's responsible person.
-She was not sure if the facility's email system allowed her to recall a email that she had sent.

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D 338	Continued From page 29 Refer to interview with the Regional Vice President of Operations (RVPO) on 08/20/26 at 4:00pm. b. Review of Resident #2's current FL-2 dated 07/27/26 revealed diagnoses included dementia, hypertension, and depression. Review of an email and attachment sent from the facility's Administrator to Resident #4's responsible person dated 08/03/26 at 8:55pm revealed: -The email contained an attachment. -The attachment was a letter and listed Resident #2's name and balance owed to the facility and listed Resident #4's name in other sections of the letter. Telephone interview with Resident #4's responsible person on 08/18/26 at 4:05pm revealed: -She received an email from the Administrator with an attachment on 08/03/26. -The attachment contained another resident's personal document. -No one from the facility had tried to contact her related to receiving another resident's personal document. Interview with the Administrator on 08/18/26 at 3:47pm revealed: -She sent an email on 08/03/26 to Resident #4's responsible person that contained another resident's name. -She attempted to call Resident #4's responsible person on 08/03/26, she did not answer and she did not leave a voice mail. -She did not make any other attempts to reach Resident #2's responsible person.	D 338		

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D 338	Continued From page 30 Refer to interview with the Regional Vice President of Operations (RVPO) on 08/20/26 at 4:00pm. _____ Interview with the Regional Vice President of Operations (RVPO) on 08/20/26 at 4:00pm revealed: -When documents were sent to the wrong person, the person who sent the documents should notify who it was sent to that the items were confidential and to destroy them as soon as this occurred. -He was not sure if the facility's email system allowed the sender to recall a email that was sent. -He was not notified about the two incidents where another resident's documents were sent to the wrong person. -He expected to be notified when this type of incident happened. -All parties that were involved in the data breach should have been notified when it occurred.	D 338		
D 352	10A NCAC 13F .1003(a) Medication Labels 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed;	D 352		

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(7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date;
(8) auxiliary statements as required of the medication;
(9) the name, address, telephone number of the dispensing pharmacy; and
(10) the name or initials of the dispensing pharmacist.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure all prescription medications were labeled for 1 of 5 sampled resident (#5) related to two different insulin products not being labeled with the name of the resident, the date of issuance, the name of the prescriber, the name and concentration of the medication, quantity dispensed, prescription serial number, directions for use, the expiration date, the name and address of the dispensing pharmacy, and the name or initials of the dispensing pharmacist.

The findings are:

Review of Resident #5's current FL-2 dated 06/29/26 revealed:
-Diagnoses included diabetes mellitus type 2, chronic obstructive pulmonary disease, hyperlipidemia, benign prostatic hyperplasia, muscle weakness, and abnormalities of gait and mobility.
-There was an order for Lantus Solostar insulin pen inject 10 units every morning. (Lantus insulin is a long-acting prescription medication used to lower blood sugar.)
-There was an order for Novolog Flexpen insulin inject 4 units before meals if the blood sugar is greater than (>) 150. (Novolog insulin is a

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D 352	Continued From page 32 rapid-acting prescription medication used to lower blood sugar.) Review of Resident #5's August 2026 electronic medication administration record (eMAR) dated 08/01/26 - 08/18/26 revealed: -There was an entry for Lantus Solostar insulin pen inject 10 units once a day every morning at 8:00am. -Lantus insulin was documented as administered daily at 8:00am from 08/01/26 - 08/18/26. -There was an entry for Novolog Flexpen insulin pen inject 4 units before meals if blood sugar > 150. -Novolog insulin was scheduled to be administered at 7:00am, 12:00pm, and 5:00pm. -Novolog was documented as administered before meals when the blood sugar was > 150 from 08/01/26 - 08/18/26. Observation of Resident #5's medications on hand on 08/19/26 at 3:18pm revealed: -There was a plastic storage box in the medication cart with the resident's name handwritten on top of the lid. -The box contained a glucometer with the resident's name written on the back of the glucometer, glucometer test strips, disposable lancets, one Lantus Solostar insulin pen, and one Novolog Flexpen insulin pen. -There was no prescription label on the Lantus or Novolog insulin pens in the medication cart. -There was a handwritten open date of 08/14/26 on the lid of the Novolog insulin pen. -There was a handwritten open date of 08/11/26 on the lid of the Lantus insulin pen. -The resident's first initial and last name were handwritten on the lid of the Lantus insulin pen. -There was a plastic ziploc bag in the medication refrigerator identified by a medication aide (MA)	D 352		

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as belonging to Resident #5.
-The plastic ziploc bag had 2 unopened boxes of Lantus Solostar insulin pens with 5 pens in each box with no prescription label on either box.
-The plastic ziploc bag had 5 unopened Novolog Flexpen insulin pens without a box and there was no prescription label on either of the insulin pens.
-There was no prescription label on the ziploc plastic bag and no name written on the bag to indicate who the insulin belonged to.
-There were no labels for the Lantus or Novolog supplies on hand to indicate the name of the resident, the date of issuance, the name of the prescriber, the name and concentration of the medication, quantity dispensed, prescription serial number, directions for use, the expiration date, the name and address of the dispensing pharmacy, and the name or initials of the dispensing pharmacist.

Interview with a MA on 08/19/26 at 3:18pm revealed:
-Resident #5's family member brought his medications to the facility because his medications were dispensed by a veteran's administration (VA) pharmacy.
-The VA pharmacy did not label the individual insulin pens.
-Sometimes the insulin boxes the family brought had prescription labels and sometimes the boxes did not have prescription labels because the family member brought only a partial supply each time.
-When there was no medication label on the insulin, she used the instructions on the eMAR to see how much insulin to administer to the resident.
-She was not aware a prescription label was required for Lantus and Novolog insulin.
-She knew which insulin belonged to Resident #5

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D 352	Continued From page 34 because other residents with insulin had prescription labels from the facility's contracted pharmacy. Interview with Resident #5's family member on 08/19/26 at 4:05pm revealed: -She usually got a 3-month supply of Resident #5's medications each time from a VA pharmacy. -She usually brought only a 1-month supply of the resident's medication, including insulin, to the facility around the beginning of each month. -The insulin pens were usually in boxes and she either brought the boxes and/or the insulin pens in a plastic ziploc bag. -She did not realize the facility needed to have the insulin box with the prescription label. -She just brought more insulin for the resident today (08/19/26) with the insulin pens in boxes that had prescription labels as requested by the facility today, 08/19/26. Second observation of Resident #5's medications on hand on 08/19/26 at 4:12pm revealed: -There was an unopened box of Lantus Solostar insulin pens with a prescription label dispensed on 03/18/26. -There was an unopened box of Novolog Flexpen insulin pens with a prescription label dispensed on 03/24/26. Interview with the Resident Care Coordinator (RCC) on 08/20/26 at 1:36pm revealed: -She was responsible for making sure medications were properly labeled. -Resident #5's family member brought his insulin in boxes that were sometimes unlabeled. -She had asked the resident's family member to bring the medication with labels in the past, but she could not recall when and did not document it.	D 352		

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D 352	Continued From page 35 -Other residents' insulin from the facility's contracted pharmacy were labeled with prescription labels. -They kept Resident #5's insulin in a plastic ziploc bag and dated each insulin pen when it was first used. Interview with the Administrator on 08/20/26 at 5:57pm revealed: -Prescription medications, including insulin, should have prescription labels. -The MAs should contact the pharmacy if a medication did not have a prescription label. -The MAs should let her, the RCC, or the Special Care Coordinator (SCC) know if a prescription medication did not have a label and they were unable to resolve the issue with the pharmacy. -Resident #5's medications were dispensed by a VA pharmacy and the resident's family member usually brought one box of the resident's insulins at a time. -She was not usually at the facility when the family member delivered the resident's medications, so she was not sure if there was a prescription label on the insulin boxes each time. -She and a MA had contacted the resident's VA pharmacy and were told they would not label individual insulin pens. -She and a MA had contacted the facility's contracted pharmacy, and they would not label Resident #5's insulin pens because they did not dispense the resident's medications. -She was aware Resident #5's insulin needed prescription labels so she would contact the pharmacy again.	D 352		