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
	HAL039016	A. BUILDING: _____ B. WING _____	R 07/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNMORE SENIOR LIVING OF OXFORD	200 COVENTRY DRIVE OXFORD, NC 27565

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 07/28/26-07/30/26.	D 000		
D 033	10A NCAC 13F .0302 (e) Design And Construction 10A NCAC 13F .0302 Design And Construction (e) The facility shall maintain in the facility and have available for review current sanitation and fire safety inspection reports. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure sanitation inspection reports were current, maintained in the facility and were available for review. The findings are: Review of the facility's current license effective 01/01/26 revealed: -The capacity was 60 residents. -The license would expire on 12/31/26. Review of the facility's Food Establishment Inspection Report revealed the last report on file was dated 11/26/24. Telephone interview with the Environmental Health Specialist on 07/30/26 at 11:56am revealed: -The facility's last sanitation inspections were	D 033	The inspection was completed on 8-3-2026. A copy of the current inspection report was obtained and is maintained at the facility and available for review as required. The Executive Director will be responsible for maintaining and monitoring all required Sanitation Inspection reports. The Executive Director will review the facility's Sanitation Inspection records quarterly to ensure all required inspections remain current and any identified concerns will be corrected immediately. 8-3-2026	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vanessa Henderson
TITLE: Executive Director
(X6) DATE: 8-31-26

Reviewed and Acknowledged 09/08/26 DC

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D 033	Continued From page 1 conducted on 11/26/24. -There was no note entered into their records that the facility contacted her about an inspection for the Food Establishment section of the facility. -Sanitation inspections were required to be conducted annually in the kitchen and residential area for facilities. -Inspections were done to ensure cleanliness and ensure people were not living in unsanitary conditions. Interview with the Dietary Manager (DM) 07/07/26 at 11:46am revealed: -She had been the DM for 3 years. -She did not realize the Food Establishment Inspection Report was outdated. -The Administrator was responsible for contacting the Environmental Health Specialist to schedule the kitchen inspections. Interview with the Administrator on 07/07/26 at 11:50am revealed: -She was not aware there was no current Food Establishment sanitation inspection for the facility. -She asked the DM when it was due and was told every two years; she thought it was due this month, July 2026. -She was not aware that she had to contact the Environmental Health Specialist to schedule the inspections.	D 033		
D 255	10A NCAC 13F .0801 (d) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (d) If a resident experiences a significant change as defined in Paragraph (c) of this Rule, the facility shall refer the resident to the resident's physician or other licensed health professional no	D 255	Resident # 3 was reassessed following the identified Significant change in Condition The resident's assessment and Care Plan	8-3-2026

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D 255	Continued From page 2 longer than three days from the date of the significant change assessment, and document the referral in the resident's record. Referral shall be made immediately when facility staff determines that a significant change as defined in Parts (c)(1)(A)-(M) poses an immediate risk to the health and safety of the resident, other residents, or staff of the facility. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure an assessment and care plan was updated within 3 days of identifying a significant change in condition for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's current FL2 dated 07/08/26 revealed: -Diagnoses included vascular dementia, hypertension, chronic kidney disease, and bipolar disease. -She was semi ambulatory. Review of Resident #3's current care plan dated 07/06/26 revealed: -Resident #3 needed minimal assistance from staff with eating and bathing. -There was nothing documented for Resident #3's care needs for grooming, toileting, transfer, ambulation and dressing. Review of Resident #3's record revealed: -She had 6 falls from 04/20/26-07/26/26. -She had a new thoracic vertebral compression	D 255	were reviewed and updated to accurately reflect the resident's current condition: The facility completed a review and reassessment of all residents to identify any significant changes in condition and to ensure each residents assessment and care plan accurately reflected the residents current needs. The RCC was re educated regarding the requirements for identifying and responding to significant changes in residents conditions including the requirement to reassess residents and update care plans timely when a significant change occurs The RCC will review resident incidents, falls, changes in	

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D 255	Continued From page 3 fracture following a fall on 06/29/26. -She had the need for physical therapy. -She had gait instability. -She needed to use her walker for ambulation. Observation of Resident #3 at various times from 07/28/26-07/30/26 revealed: -She ambulated using her rollator walker. -Resident #3's gait was rapid with short shuffling steps while using her walker. Interview with a personal care aide (PCA) on 07/30/26 at 3:45pm revealed: -Resident #3 used a rollator to ambulate. -She had to be reminded to lock her rollator when transferring. -She required monitoring to prevent falls. Interview with a medication aide (MA) on 07/30/26 at 3:00pm revealed: -Resident #3 had frequent falls. -She needed to be monitored to prevent falls. Interview with Resident #3's primary care provider (PCP) on 07/30/26 at 12:53 revealed: -Resident #3 had a new compression fracture that was obtained following a fall. -Resident #3 had an unsteady gait. -Resident #3 had a recent increase in the number of falls she had, so she expected the staff to monitor Resident #3 frequently to prevent falls. Interview with the Resident Care Coordinator (RCC) on 07/30/26 at 6:00pm revealed: -She had been in the RCC position for less than 1 month. -She was aware of the change in condition for Resident #3 with a recent increase in the number of her falls. -She was responsible for updating the care plan.	D 255	Condition, hospital/ER visits, and other identified change to ensure assessments and care plans are updated appropriately and timely. The Executive Director will conduct periodic audits of resident records to verify compliance. Any indentified concerns will be corrected immediately and additional staff education will be provided as necessary.	

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D 255	Continued From page 4 Interview with the Administrator on 07/30/26 at 6:15pm revealed: -The RCC was responsible for updating the care plan. -She was aware that the care plan required updating with a significant change in condition.	D 255		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care for 3 of 3 sampled residents (#6, #7, and #8) including a resident that needed limited staff assistance with showering and grooming who had severely matted hair (#6), a resident who required extensive staff assistance with showering who had greasy and matted hair (#8), and a resident who required extensive staff assistance with bathing and grooming whose hair was greasy, face unshaved, and had an odor (#7). The findings are: 1. Review of Resident #6's current FL2 dated 02/06/26 revealed: -Diagnoses included cerebrovascular accident. -She needed assistance from staff with bathing	D 269	Residents #6, #7, and #8 were assessed for their immediate personal care and grooming needs. Personal care was provided, including bathing, grooming hair washing and other hygiene needs as appropriate. The facility reviewed all residents to identify any unmet personal care, bathing, grooming or hygiene needs. The RCC and direct Care staff were educated regarding the facility's responsibility to provide personal care according to each residents care plan. Education included	7-31-26 8-6-26

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D 269	Continued From page 5 and dressing. -She was semi-ambulatory. Review of Resident #6's Resident Register revealed an admission date of 02/19/2025. Review of Resident #6's care plan dated 02/04/26 revealed: -She was sometimes disoriented. -She was forgetful and needed reminders. -She needed limited assistance from staff for ambulation, bathing, dressing, and grooming/personal hygiene. Review of Resident #6's skin monitoring sheets from 07/01/26-07/28/26 revealed: -There were 9 skin monitoring sheets completed for Resident #6. -It was documented Resident #6 refused a shower 2 of 9 opportunities. -The skin monitoring sheets were signed by the personal care aide (PCA) and medication aide (MA). Observation of Resident #6 on 07/30/26 at 11:01am revealed: -She was sitting in her wheelchair in the common area. -Her hair looked like it was pulled up into a bun. -There was no clip or hair tie holding her hair into the bun position. -Her hair was severely matted. -Her hair was greasy and had little white flecks throughout her hair. Interview with Resident #6 on 07/30/26 at 11:05am revealed: -She was not aware her hair was matted. -Staff did not assist her with bathing or brushing her hair.	D 269	bathing, grooming, hair care, Personal hygiene, proper documentation of care provided, and appropriate handling of resident refusals. Staff were educated that when a resident refuses personal care, the refusal must be documented and care should be re-attempted as appropriate. Repeated refusals must be reported to the RCC so that the residents needs can be reviewed and appropriate follow-up can occur. The RCC will be responsible for reviewing bathing and personal care documentation to ensure residents receive scheduled baths and required grooming and	

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D 269	Continued From page 6 -She washed and brushed her hair. Interviews with a MA on 07/30/26 at 11:32am and 2:57pm revealed: -She had worked at the facility for about a month. -Resident #6's hair had always been matted. -Resident #6 refused to let staff touch her hair. -She had not been a part of a meeting to address Resident #6's hair. Interview with a PCA on 07/30/26 at 12:08pm revealed: -She had only been working at the facility for 2 days. -She was told by other staff members to not worry about Resident #6's hair because she would not let anyone touch it. Telephone interview with Resident #6's family member on 07/30/26 at 12:31pm revealed: -He had seen Resident #6's hair during his last visit in December 2025 or January 2026. -He had talked to the facility regarding Resident #6 being unkept and her hair not being washed or brushed but could not remember when or who he had spoken to. -He believed Resident #6's hair was so severely matted that her head would need to be shaven. -He believed it was unhealthy for her and was scared because he was not sure if she had wounds or bugs in her hair. -He had told the facility that he was willing to do whatever it took to get her hair fixed which included paying extra money to have her seen by a professional hairdresser. -He believed that the facility may have just given up on Resident #6 about her hair. Interview with a second PCA on 07/30/26 at 2:29pm revealed:	D 269	Personal care. The RAC will monitor documentation for resident refusal and ensure appropriate follow-up occurs when residents repeatedly refuse personal care. Any identified missed care, incomplete documentation, or unmet personal care needs will be addressed immediately with the responsible staff member, and additional education will be provided as necessary.	

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D 269	Continued From page 7 -She had tried to wash and brush Resident #6's hair but she would refuse. -Resident #6 would tell her the spirits would not let her wash her hair. -She let the Resident Care Coordinator (RCC) know about her concerns with Resident #6's hair but she could not remember when. -She was told to just keep encouraging Resident #6 to wash and brush her hair and to not worry about it if Resident #6 kept refusing. -She did not think there was any way to just wash and brush Resident #6's hair; it would need to be shaved. Interview with a second shift MA on 07/30/26 at 3:31pm revealed: -Resident #6 would not let anyone touch her hair. -Resident #6 would tell her that God would not let her wash or brush her hair. -She had not been part of a meeting to address Resident #6's hair. Interview with the RCC on 07/30/26 at 5:19pm revealed: -She had been the RCC since July of 2026. -Resident #6 refused to let anyone touch her hair. -Resident #6 had told her the spirits would let her know when it was time to wash and brush her hair. -Before she became the RCC she had tried to discuss her concerns regarding Resident #6's hair to the previous psychology provider but was told it was Resident #6's right to have her hair that way. -She had not discussed Resident #6's hair with the new psychology provider. -She had not discussed Resident #6's hair with her family member. Interview with the Administrator on 07/30/26 at	D 269		

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D 269	Continued From page 8 6:41pm revealed: -Resident #6 was admitted into the facility with her hair matted. -She had spoken with Resident #6's family member regarding her hair and was told that Resident #6 makes her own decisions. -She had spoken to Resident #6's PCP regarding her hair but was told it was her right to have her hair matted. -She had spoken to the ombudsman and was told that it was Resident #6's right to have her hair matted but she could not remember when. -She thought she spoke with the psychology provider about her delusions of the spirits and God not wanting her to wash or brush her hair but she could not remember when. Attempted telephone interview with Resident #6's PCP on 07/30/26 at 12:05pm and 4:24pm was unsuccessful. 2. Review of Resident #8's current FL2 dated 03/23/26 revealed: -Diagnoses included Dementia and schizophrenia. -She needed assistance from staff with bathing and dressing. -She was semi-ambulatory. Review of Resident #8's Resident Register revealed an admission date of 06/10/14. Review of Resident #8's care plan dated 02/23/26 revealed: -She needed extensive assistance from staff for bathing. -She was independent with eating, toileting, ambulation, dressing, grooming, and transferring. Review of Resident #8's skin monitoring sheets	D 269		

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D 269	Continued From page 9 from 07/01/26-07/28/26 revealed: -There were 10 skin monitoring sheets completed for Resident #8. -It was documented Resident #8 refused to have her hair shampooed 1 of 10 opportunities. -It was documented Resident #8 refused a shower 1 of 10 opportunities. -The skin monitoring sheets were signed by the personal care aide (PCA) and medication aide (MA). Observation of Resident #8 on 07/30/26 at 11:39am revealed: -She was sitting in the hallway across from the nurse's station. -Her hair was severely greasy, and a mat of hair was forming on the back of her head. Interview with Resident #8 on 07/30/26 at 1:10pm revealed: -She showered once or twice a week. -She washed and brushed her hair on her own. Interview with a PCA on 07/30/26 at 2:29pm revealed: -Residents were scheduled showers 3 times a week. -The PCAs filled out a skin monitoring sheet after each shower. -When a resident refused a shower, the refusal would be documented on the skin monitoring sheet. -She had noticed Resident #8's hair looked greasy and needed to be brushed. -Resident #8 would let you wash and brush her hair sometimes, but she needed encouragement. -She had not notified the Resident Care Coordinator (RCC) about Resident #8's refusals to let her wash and brush her hair in the past.	D 269		

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D 269	Continued From page 10 Interview with a MA on 07/30/26 at 2:57pm revealed: -She was not scheduled to provide showers for the residents. -She would only assist with showers if a PCA asked for assistance. -Resident #8 would let you wash and brush her hair. -She did not notice Resident #8's hair today because she was focused on administering medications. Interview with a second shift MA on 07/30/26 at 3:31pm revealed: -Resident #8 did refuse to have her hair washed by the PCAs sometimes. -Resident #8 would let her wash her hair, but she did not have time on second shift because she was the only MA for the entire building. Interview with the RCC on 07/30/26 at 5:19pm revealed: -She did not notice Resident #8's hair was greasy and matted in the back. -The residents were showered 3 times weekly. -The PCA's filled out a skin monitoring sheet after each shower and they were reviewed by the MA. -When a resident refused a shower the PCAs would document the refusal on the skin monitoring sheet. -She expected the PCAs to assist the residents with showers. -She expected the MA to assist the PCA with showering the resident if they refused. Interview with the Administrator on 07/30/26 at 5:19pm revealed: -Resident #8 refused to have her hair shampooed, she would wipe the shampoo off. -Resident #8 would only let the PCAs use water	D 269		

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D 269	Continued From page 11	D 269		

on her hair.
-She had not notified the Primary Care Provider (PCP) regarding the refusals because it was her right not to have shampoo in her hair.

Attempted telephone interview with Resident #8's family member on 07/30/26 at 12:02pm was unsuccessful.

Attempted telephone interview with Resident #8's PCP on 07/30/26 at 12:08pm was unsuccessful.

3. Review of Resident #7's FL2 dated 07/08/26 revealed diagnoses included dementia, hypertension, hyperlipidemia, depression disorder.

Review of Resident #7's care plan dated 07/08/26 revealed:
-He needed extensive assistance from staff with bathing, toileting and grooming.
-He needed moderate assistance from staff with dressing.
-He needed minimal assistance from the staff with eating.

Observation of Resident #7 on 07/30/26 at 11:00am revealed:
-His hair was greasy and not combed.
-His face was not shaved.
-He had on wrinkled clothing.
-He had a smell of urine.

Review of Resident #7's skin monitoring sheets from 07/01/26-07/28/26 revealed:
-There were 9 skin monitoring sheets completed for Resident #7.
-It was documented Resident #7 refused a shower 4 of 9 opportunities.
-The skin monitoring sheets were signed by the

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D 269	Continued From page 12 personal care aide (PCA) and medication aide (MA). Telephone interview with Resident #7's family member on 07/30/26 at 5:15pm revealed: -Resident #7 would resist personal care from certain personal care aides (PCA) but did better with others. -She would prefer the staff attempt to assist Resident #7 with showers more frequently. -Resident #7 did not refuse showers when she was present. Interview with a medication aide (MA) on 07/30/26 at 3:16 revealed: -Resident #7 required assistance from two PCAs to shower, because he would become combative. -His family was called to be present during showers. -He did not have an as-needed medications to calm him before shower attempts so that personal care could be completed. -The primary care provider (PCP) had not been contacted to obtain as-needed medications. Interview with a second MA on 07/30/26 at 3:42pm revealed: -Resident #7 refused showers on second shift. -He would only shower once his family member arrived. -He refused to have his hair shampooed or groomed while in the shower. Interview with the Resident Care Coordinator (RCC) on 07/30/26 at 5:23pm revealed: -The PCAs had adjusted the shower schedule to accommodate Resident #7's comfort level with showers when a family member was present. -The PCP was aware of his refusal of showers. -No other alternative actions had been attempted.	D 269		

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D 269	Continued From page 13 -She was concerned about the appearance of Resident #7. -It was the responsibility of the RCC to adjust the care plan and follow up with the PCP. Interview with the Administrator on 07/30/26 at 6:27pm revealed: -The staff were expected to make different attempts to get residents to shower. -It was the responsibility of the RCC to follow up with the PCP regarding resident behavior issues such as refusal of personal care. -She was concerned that Resident #7 would go days without having a shower. Attempted telephone interview with Resident #7's PCP on 07/30/26 at 1:00pm was unsuccessful. Based on observations and record review it was determined Resident #7 was not interviewable.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by:	D 270	Resident # 3 was Immediately reassessed following the identified concerns and repeated falls, The resident's Care plan was reviewed and updated to reflect her Current Supervision, mobility and fall-risk needs. Fall-Prevention interventions were implemented based on the residents assessed needs staff were instructed	7-31-26 S

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D 270	Continued From page 14 TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision according to the residents' needs for 1 of 5 sampled residents (#3) who had multiple falls resulting in a fracture. The findings are: Review of Resident #3's current FL2 dated 07/08/26 revealed: -Diagnoses included vascular dementia, chronic kidney disease, stage 3, bipolar disease, and hypertension. -She was semi ambulatory. -The orientation section was blank. Review of Resident #3's care plan dated 07/06/26 revealed: -She was independent with ambulation, transfers, toileting, and grooming. -She required minimal assistance from staff with eating and bathing. -She was oriented. Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 07/21/26 revealed she had LHPS tasks for assistance with transfers, ambulation with an assistive device, and compression stockings. Review of Resident #3's undated incident reports revealed: -At 6:10am, date not specified, Resident #3 was found in the bathroom holding on to the grab bars, stating she had fallen. -At 11:30pm, date not specified, Resident #3 was found by the medication aide (MA) sitting on the floor.	D 270	to provide increased supervision and monitoring, encourage and assist the resident with the use of her rollator/ walker, and maintain a safe and Clutter- free environment Resident #3 was relocated to a room closer to the nursing station to allow for increased observation and monitoring All residents were reviewed to identify individuals with a history of falls or increased risk for falls any identified concerns were corrected immediately and care plans were updated as necessary to reflect each residents current needs, The RCC and direct care staff	

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D 270	Continued From page 15 -Resident #3 told the MA she fell on her knees, was not hurt and wanted to go to church; she refused to go to the Emergency Department (ED). Review of Resident #3's 72-hour fall follow-up reports for April 2026 revealed: -Post-fall vital signs and assessment were completed from 04/20/26 through 04/22/26. -On 04/20/26 during the first shift there was documentation Resident #3 was positive for soreness around an injured area but there was no area of injury documented; she was negative for changes in behavior, difficulty walking, bruising or requiring as-needed pain medication. Review of Resident #3's record revealed there was no incident report dated 04/20/26 available for review. Review of Resident #3's physician's order dated 04/20/26 revealed an order for physical therapy (PT) and occupational therapy (OT) for gait instability due to diagnosis of osteomyelitis of multiple joints. Review of Resident #3's 72-hour fall follow-up reports for May 2026 revealed: -Post-fall vital signs and assessment were initiated for Resident #3 on 05/11/26. -Vital signs and assessment on 05/11/26 were negative for difficult walking, soreness around injured area, or behavior changes. -Resident #3's assessment on 05/12/26 was positive for soreness around an injured area and she required Tylenol (an over-the-counter medication used to treat pain). Review of Resident #3's record revealed there was no incident report dated 05/11/26 available	D 270	re-educated regarding fall prevention and the requirement to provide supervision according to each residents assessed needs, care plan, and current condition. Education included proper use of assistive devices, required resident checks, documentation of supervision, immediate reporting and documentation of falls, and reporting changes in condition to the RCC. The RCC will be responsible for reviewing fall documentation monitoring logs and care plans to ensure that required supervision and fall-prevention interventions are being completed and documented. The RCC	

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D 270	Continued From page 16 for review. Review of Resident #3's incident report dated 06/28/26 revealed: -At 11:30pm, Resident #3 was found sitting on the floor in front of her bed. -She said she had slipped. -She said her hip was sore. -She refused to go out to the ED for an assessment. Review of Resident #3's primary care provider's (PCP) progress note dated 06/29/26 revealed: -Resident #3 was seen for evaluation and management of pain. -Her current pain level was 3 out of 5. -Resident #3 reported having a fall to the PCP earlier on 06/29/26 and she had not told the staff about the fall. -Resident #3 agreed to be seen in the ED for x-rays due to the recent falls. Review of Resident #3's hospital discharge note from the orthopedic specialist dated 06/29/26 revealed: -Resident #3 was hospitalized on 06/29/26 with a diagnosis of thoracic compression fracture and pain. -She could use warm compresses to her back three times per day. -She was given Tylenol 1000mg three times per day as needed in addition to her already scheduled pain medications. -She should use her walker to take the pressure off of her back. -She should follow up with PT. Review of Resident #3's PCP's progress note dated 07/06/26 revealed a second order for Resident #3 to begin PT based on the	D 270	Will review all falls to determine whether additional interventions, reassessment, care-plan updates, Provider notification, or therapy follow up are required. The Administrator will provide oversight to ensure that the corrective measures remain in place and that identified concerns are Corrected promptly.	

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D 270	Continued From page 17 discharge summary from the hospital on 06/29/26. Review of Resident #3's record revealed there were no PT notes available for review. Interview with the Resident Care Coordinator (RCC) on 07/30/26 at 6:00pm revealed: -She was aware of Resident #3's falls. -She did not remember the dates of the 2 incident reports that were not dated. -Most of Resident #3's falls had occurred when she got out of bed. -Resident #3 was aware to use her call bell before getting out of bed. -Resident #3 had to be reminded to use her rollator walker. Interview with a MA on 07/30/26 at 4:19pm revealed: -She worked 3rd shift most of the time. -Resident #3 would not call for assistance when getting out of bed. -She and the personal care aide (PCA) would round and check residents hourly. -There was no documentation process in place to log the hourly checks. Interview with Resident #3 on 07/28/26 at 4:13pm revealed: -She was independent with using her rollator walker to ambulate, with transfers, toileting, showering, grooming and dressing. -She had numerous falls recently. -She sometimes felt dizzy before falling. -Her pain was an 8 on a scale from 0 to 10 if she did not take pain medication. -She had increased pain following her falls and had taken Tylenol 1000mg as needed for increased pain.	D 270		

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D 270	Continued From page 18 -She was told by the RCC that she would have to pay out-of-pocket if PT came to the facility for therapy sessions, so she had not been receiving PT services. Interview with a PCA on 07/30/26 at 4:00pm revealed: -Resident #3 did not use her rollator walker while ambulating. -She did not wear proper shoes. -She was concerned that she continued to fall. -She checked on her every hour and reminded her to use her rollator. Interview with a second PCA on 07/30/26 at 3:45pm revealed: -She was aware of Resident #3's falls. -She had been told by the MA to check on Resident #3 frequently. -There was no documentation log for the PCAs to use to verify Resident #3 was monitored frequently. -She encouraged Resident #3 to use her rollator. -Resident #3 forgot to lock her rollator. -She had seen Resident #3 without her rollator in the bathroom. -There was clutter in her room which caused the resident to have to maneuver to get around in her room. -She had talked with the RCC about the need to declutter Resident #3's room. -A family member of Resident #3 had decluttered the room, which made it easier for Resident #3 to get around. Interview with a second MA on 07/30/26 at 3:00pm revealed: -Resident #3 did not always inform staff when she had a fall. -Resident #3 had been moving slower since	D 270		

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D 270	Continued From page 19 having a fall while ago that happened at her church, but she continued to remain independent with her care after the fall. Interview with Resident #3's PCP on 07/30/26 at 12:53 revealed: -Resident #3 had a thoracic fracture identified on an x-ray 06/29/26. -She had an unsteady gait. -She had discussed Resident #3's falls with staff and had ordered PT in April 2026. -She thought Resident #3 had been receiving PT. -It was expected that staff would assist Resident #3 for safety to prevent falls. -Staff should monitor and remind Resident #3 to use her rollator. -She would expect staff to monitor Resident #3 more since she had frequent falls. Interview with the RCC on 07/30/26 at 6:00pm revealed: -She was responsible for reviewing incident reports and implementing a fall prevention plan. -It was expected that staff would check Resident #3 every 30 minutes following a fall, otherwise residents were checked every 1 to 2 hours. -There was no documentation tool available for PCAs to document the 30-minute resident checks. -Resident #3 had been ordered PT but never received PT services due to an issue with her insurance. -No other processes had been attempted to prevent Resident #3 from falling. Interview with the Administrator on 07/30/26 at 6:15pm revealed: -It was all of the staffs' responsibility to monitor and prevent residents from falling. -It was the RCC's responsibility to make sure staff	D 270		

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D 270	Continued From page 20 were monitoring residents following a fall. Attempted telephone interview with Resident #3's family member on 07/30/26 at 4:30pm was unsuccessful. Attempted interview with the housekeeper on 07/30/26 at 4:40pm was unsuccessful. The facility failed to ensure supervision for 1 resident (#3) who required assistance from staff with transfers and ambulation and had a history of falls. Resident #3 had six unwitnessed falls, the last one resulted in a thoracic compression fracture and pain, and there was no documentation that staff increased their supervision of Resident #3 or implemented other fall prevention measures including physical therapy (PT). This failure resulted in serious physical harm and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/30/26 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 29, 2026.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION	D 273	Resident #3s physician orders and referrals were reviewed. The physical therapy referrals was followed up on,	7-31-26

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D 273	Continued From page 21 Based on the observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 5 sampled residents (#3) who had an order for physical and occupational therapy due to multiple falls. The findings are: Review of Resident #3's FL2 dated 07/08/26 revealed: -Diagnoses included vascular dementia, chronic kidney disease, hypertension, bipolar disease. -She was semi ambulatory. Review of Resident #3's care plan dated 07/06/26 revealed: -She was independent with ambulation, transfers, toileting, and grooming. -She was oriented. Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 07/21/26 revealed: -She had a task for transfers with assistance from staff. -She had a task for ambulation with an assistive device. -She had a task for compression hose. Review of Resident #3's physician order dated 04/20/26 revealed an order for physical therapy (PT) and occupational therapy (OT) due to gait instability. Review of Resident #3's incident reports revealed: -Resident #3 had 8 falls between 04/20/26 and 06/28/26, six of which were unwitnessed at the	D 273	and Resident #3 began receiving physical therapy services as ordered. An audit was completed on all residents to identify any outstanding Physician orders, referral, therapy orders, or follow-up appointments. Any identified concerns were immediately addressed to ensure residents received the ordered services and appropriate follow-up. The RCC and MA were re-educated on the facility's procedure for reviewing physician orders, hospital discharge paperwork, referrals and therapy orders. Staff	8-27-26

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D 273	Continued From page 22 facility and two that were witnessed by church staff; 1 in church and 1 getting on the church van. -On 5/28/26 at 10:32pm, a medication aide (MA) documented Resident #3 returned from emergency department (ED); according to the hospital staff who called her to give her report, Resident #3 had a sacral fracture as a result of the fall at church the previous day. Request for Resident #3's hospital discharge summary dated 05/28/26 was not provided by survey exit. Review of Resident #3's primary care provider's (PCP) progress note dated 06/29/26 revealed: -Resident #3 was seen for evaluation and management of pain. -Her current pain level was 3 out of 5. -Resident #3 reported having a fall to the PCP earlier on 06/29/26 and she had not told the staff about the fall. -Resident #3 agreed to be seen in the ED for x-rays due to the recent falls. Review of Resident #3's hospital discharge note from the orthopedic specialist dated 06/29/26 revealed: -Resident #3 was hospitalized on 06/29/26 with a diagnosis of thoracic compression fracture and pain. -Resident #3 should follow up with PT. Review of Resident #3's PCP progress note dated 07/06/26 revealed a second order for Resident #3 to begin PT based on the orthopedic discharge note dated 06/29/26.. Interview with Resident #3 on 07/28/26 at 4:13pm revealed: -She had numerous falls recently.	D 273	were instructed that all referrals must be processed and followed through until services are initiated. If a provider is unable to accept a referral, the RCC must immediately contact another provider and document all follow-up attempts. The RCC will be responsible for monitoring all new physician orders and referrals to ensure they are processed and completed timely. The Executive Director will review/audit physician orders and referrals weekly for 4 weeks and monthly for 3 months to ensure continued compliance	

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D 273	Continued From page 23 -She sometimes felt dizzy before falling. -She had back pain. -Her pain was an 8 on a scale from 0 to 10 if she did not take pain medication. -She had to take Tylenol (an over-the-counter medication used to treat pain) when her scheduled pain medication did not work. -She was told by the Resident Care Coordinator (RCC) that she would have to pay if PT came to the facility for therapy sessions. -She did not remember how long ago the RCC had told her about PT not being able to see her. -She had not had PT this year. Telephone interview with orthopedic clinic scheduler on 07/29/26 at 11:00am revealed Resident #3 had not seen PT yet, but was scheduled to begin PT services on 08/17/26. Interview with a MA on 07/29/26 at 3:21pm revealed: -When residents returned from the hospital with discharge papers, she would read them, check for new medication orders and place them in the RCC's office. -She only checked for medication orders because she administered medications; she did not check for referral orders. -Resident #3 fell because she would forget to use her rollator. Interview with a second MA on 07/30/26 at 4:00pm revealed when residents returned from the hospital, she would read the discharge paperwork, check for new medication orders, and place them in the RCC's office for follow up. Interview with Resident #3's PCP on 07/30/26 at 12:53pm revealed: -She was not aware that Resident #3 did not	D 273	Any identified concerns will be corrected immediately and additional staff education will be provided as needed.	

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D 273	Continued From page 24 receive PT when she had ordered it back in April 2026. -She expected the PT services to start within 1 week after writing the order. -She wrote the order 04/20/26 to aid in preventing further falls and education and assessment for prevention for the resident and staff. -The goal for writing the orders was to prevent injuries. -The PT teaching the resident protective measure when feeling like she might fall could prevent injuries. -She was concerned that PT had not been initiated on Resident #3. -The medical decisions that she made since April 2026 were based on the patient receiving PT since late April. -The staff should have reached out to her when PT refused the referral. -She would have reached out to other PT providers for assistance. -Resident #3 was sent out for an x-ray on 06/29/26 following a pain assessment due to a fall and was diagnosed with a fracture. Interview with the RCC on 07/30/26 at 5:23pm revealed: -She was aware of the PT orders for Resident #3. -She had emailed documentation on 07/21/26 at 2:31pm showing a PT referral was sent to the facility's contracted therapy and the reply was they no longer accepted Resident #3's insurance. -She was not in the role as RCC when the initial PT order was written on 04/20/26. -She was concerned that Resident #3 had not received therapy as ordered. -She was able to obtain a PT appointment for 08/17/26 by calling Resident #3's orthopedic office.	D 273		

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D 273	Continued From page 25 Interview with the Administrator on 07/30/26 at 6:27pm revealed: -She was aware that Resident #3 had not started PT. -She was aware that the RCC had attempted to reach out to two other therapy providers. -She was concerned with the number of falls Resident #3 had. Attempted interview with Resident #3's orthopedic provider on 07/30/26 at 11:00am was unsuccessful. Attempted interview with the scheduled PT on 07/30/26 at 11:00am was unsuccessful. The facility failed to ensure health care referral and follow up for one resident (#3) who had an order for physical therapy (PT) and occupational therapy (OT) following a fall and to help prevent further falls. The referral was never initiated resulting in the resident not receiving the ordered therapy and had 8 subsequent falls, two of which resulted in pain and a fracture. This failure was detrimental to the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/30/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 13, 2026.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 283	The facility immediately corrected the identified food storage and sanitation	7-31-26

Division of Health Service Regulation

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D 283	Continued From page 26 (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: Based on observations, interviews, and record reviews, the facility failed to ensure that all food items stored by the facility were protected from contamination related to proper storage and that food served to a resident was left uncovered during transport through the facility. The findings are: 1. Observation of a food storage bin in the kitchen on 07/28/26 at 2:18pm revealed: -The container was sitting next to the reach in freezer in the kitchen. -The lid to the bin was broken and stored inside the bin -There was an open 50-pound bag of sugar	D 283	Concerns New food-Storage Containers were purchased to replace broken and missing lids All food items in the Kitchen, refrigerator, freezer, and dry-Storage areas were inspected. Open food items were properly sealed, labeled, and dated, and any food that could not be verified as safe or within the appropriate storage period was discarded. Staff were also instructed that all resident meals must remain properly covered while being transported from the kitchen to residents. The Executive Director completed an audit of all food-	

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D 283	Continued From page 27 inside the bin. -There was a black cup laying inside the bin. Observation of a small food storage bin in the kitchen on 07/28/26 at 2:18 revealed: -The bin did not have a cover. -There was an open 25-pound bag of rice that was stored in the bin. -There were 2 open bags of pasta stored inside the bin Observation of the reach-in freezer on 07/28/26 at 2:19pm revealed: -There was an open bag of cookie dough that was not labeled with an open or discard date. -There was an open bag of chicken breasts that was not labeled with an open or discard date. -There were 2 resealable plastic bags of sliced carrots that were not labeled with an open or discard date. -There was an open frozen pie crust that was not labeled with an open or discard date. -There were 2 resealable plastic bags of chicken drumsticks that were not labeled with an open or discard date; the bags were filled with ice crystals. -There was an open bag of frozen breaded shrimp that was not labeled with an open or discard date. Interview with the cook on 07/28/26 at 3:10pm revealed: -All opened food in the freezer should be sealed and labeled with the date opened. -All food opened and stored in the bins should be sealed and covered. -The large bin with the sugar had no lid because it was broken but could not remember when it had broken. -The black cup was used to scoop up the sugar	D 283	Storage areas to ensure food was properly covered, sealed, labeled, dated, and stored in appropriate containers, The Dietary Manager and dietary staff were educated on proper food storage, labeling, dating, covering and sanitation requirements. Special Care Unit staff were educated on the requirement to keep resident meals covered during transportation and until the meal is delivered to the resident. The Dietary Manager will be responsible for monitoring the kitchen, refrigerators, freezers, dry storage areas and meal transportation	

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D 283	Continued From page 28 stored in the bin. Observation of the reach-in cooler on 07/29/26 at 2:02pm revealed there was an open resealable plastic bag that contain uncut turkey deli meat. Interview with the cook on 07/29/26 at 3:15pm revealed: -She used the turkey to make sandwiches for lunch. -She must have forgotten to reseal the plastic bag. -All food stored in the reach-in cooler should be resealed after use. Interview with the Dietary Manager (DM) on 07/29/26 at 9:45am revealed: -All open foods should be sealed, then labeled with an open date. -The large food storage bin had a lid, but it broke and could not remember when. -She had asked for new bins but had not received any new bins yet. Interview with the Administrator on 07/30/26 at 6:20pm revealed: -She expected the food to be labeled when opened. -She expected food containers to be sealed. 2. Observation of the lunch meal service in the Special Care Unit (SCU) on 07/28/26 at 11:57am revealed: -The plates of food were distributed to the residents. -The Special Care Unit Coordinator (SCC) placed a plate of food on the table where no residents were seated. -A resident was observed walking towards the seat where the plate of food had been placed and	D 283	Practices to ensure continued Compliance. The Executive Director will conduct periodic audits to verify that food is properly stored, sealed labeled, dated, and covered during transportation. Any Concerns identified will be corrected immediately, and additional staff education will be provided as necessary.	

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D 283	Continued From page 29 sat down at 12:20pm. -The resident's family member asked the SCC if she could reheat the plate of food. -The SCC was observed removing the plate from the table then walked out of the SCU doors with the food uncovered at 12:23pm. -The SCC returned to the SCU with the uncovered plate of food and placed it in front of the resident at 12:24pm. Interview with the SCC on 07/30/26 at 4:10pm revealed: -She did not realize she had to cover the plate when walking with it out of the SCU to reheat. -She did not realize the resident did not come down for lunch right away and was busy assisting other residents. -She should have kept the plate in the warmer until the resident was seated at the table. Interview with the Administrator on 07/30/26 at 6:20pm revealed: -She expected food plates to be kept in the warmer until they were served to the residents. -The food plate should have been covered before it left the SCU to be reheated.	D 283		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that	D 285	The facility immediately Ordered additional food to ensure that the required three-day supply of perishable food and five-day supply of non perishable food was available in accordance with	8-5-26

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D 285	Continued From page 30 is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a 3-day supply of perishable food and a 5-day supply of nonperishable fruits and vegetables were available. The findings are: Review of the facility's current license effective 01/01/26 revealed the facility was licensed for 60 beds. Review of the facility's census on 07/28/26 revealed there were 39 residents residing in the facility. Observation of the food supply in facility's kitchen on 07/28/26 at 1:53pm revealed: -There were three #10 cans (a #10 can with 21 half cup servings per can) of collard greens. -There were five #10 cans of diced beets. -There were five #10 cans of chopped spinach. -There were two #10 cans of baked beans. -There were three #10 cans of black beans.	D 285	the facility's menus and regulatory requirements The Executive Director completed and audit of the facility food inventory to ensure that adequate quantities of perishable and nonperishable foods were available to meet the needs of all residents and to verify Compliance with the required food supply. The New Dietary Manager was educated regarding her responsibilities for maintaining adequate food inventory at all times, including ensuring that the facility maintains a minimum three-day supply of perishable food and five-day supply of nonperishable	

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D 285	Continued From page 31 -There were four #10 cans of solid pumpkin. -There was one #10 can of fruit cocktail. -There was one 14-ounce box of cereal with ten 1 cup servings. -There was one 16-ounce jar of peanut butter. -There was one 7.25-ounce box of macaroni and cheese. -There were six 80-ounce bags of grits; 366 quarter cup servings. -There were four 5-pound boxes of pancake mix; 150 three-inch pancakes. -There were sixteen 28-ounce boxes of cream of wheat; 288 quarter cup servings. -There were seven 42-ounce containers of oatmeal; 210 half cup servings. -There were three 56-ounce bags of stuffing mix; 42 half cup servings. -There were 4-gallon size resealable bags full of frozen chicken drumsticks; the inside of the bags had ice crystals. -There was a gallon size resealable bag that was half full of frozen green beans. -There was a large clear bag, a quarter full of frozen cookie dough. -There was a large clear bag that contained 6 frozen chicken breasts. -There were 4-gallon size resealable bags full of frozen carrots. -There was a half a loaf of raisin bread available. -There were no fresh vegetables available. -There was no milk available. -There was no fresh or frozen fruit available. -There was no hot tea available. -There were no fresh eggs available. Observation of the food items after the facility's Tuesday food truck delivery on 07/29/26 at 2:01pm revealed: -There was one 3-pound bag of fresh broccoli; 16 servings.	D 285	food based on the facilitys menus and resident consus The Dietary manager will be responsible for routinely monitoring the food inventory and placing food orders as necessary to maintain the required supply. The Exactive Director will conduct periodic audits of the food inventory to verify continued compliance. Any concerns identified during an audit will be corrected immediately and additional education will be provided as needed.	

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D 285	Continued From page 32 -There was one gallon of milk; 16 servings. -There was one gallon of milk that was half full; 8 servings. -There were three 6-pound containers of frozen lasagna; 36 one cup servings. -There was one 20-pound box of frozen cookie dough. -There was one 10-pound box that contained 175 frozen biscuits. -There was one box that contained 240 frozen dinner rolls. -There were six frozen soup containers; 336 servings. -There were two 10-pound boxes of breakfast sausage patties; 214 servings. -There were 40-pounds of chicken drumsticks. -There were six gallon size resealable bags that contained frozen pork chops; 40 servings. -There was one quarter of 8-pound whole turkey breast; 16 servings -There was one half of a whole ham; 36 servings. -There was one half of a 5-pound package of sliced cheese; 30 servings. -There was a 10-pound box of fresh oranges. -There was a box that contained twelve 46 fluid ounce cartons of apple juice; 69 servings. Review of the facility's breakfast menu for the week of 07/26/26 -08/01/26 revealed: -On Monday, apple juice, oatmeal, fresh whole apple, hard cooked egg, sausage patty, fruit muffin, milk and hot tea were to be served. -On Tuesday, apple juice, cream of wheat, whole orange, baked spinach omelet, bacon, biscuit, milk, and hot tea were to be served. -On Wednesday, apple juice, cream of rice, banana, Belgian waffle, fruit compote, sausage patty, milk, and hot tea were to be served. -On Thursday, apple juice, oatmeal, fresh whole apple, bake vegetable omelet, Canadian bacon,	D 285		

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D 285	Continued From page 33 wheat toast, milk, and hot tea were to be served. -On Friday, apple juice, cream of wheat, fresh whole orange, whole wheat pancakes, sausage patty, milk, and hot tea were to be served. -On Saturday, apple juice, cream of rice, banana, scrambled eggs with cheese, raisin toast, milk and hot tea were to be served. -On Sunday, apple juice, oatmeal, fresh whole apple, egg and cheese croissant, bacon, milk and hot tea were to be served. Review of the facility's lunch menu for the week of 07/26/26 -08/01/26 revealed: -On Monday, Hawaiian ham, chicken vesuvio, cheesy rice, asparagus, wheat dinner roll, coconut cream cake, milk, and hot tea were to be served. -On Tuesday, asian barbecue turkey, baked tilapia, lemon risotto, oven roasted vegetables, wheat dinner roll, chocolate pudding torte, milk, and hot tea were to be served. -On Wednesday, bake thyme chicken, pot roast, oven brown potatoes, summer squash, wheat dinner roll, apple crisp, milk and hot tea were to be served. -On Thursday, roast turkey diane, sirloin beef tips with mushroom gravy, herbed green beans, wheat dinner roll, lemon bar, milk and hot tea were to be served. -On Friday, bake chicken, Italian meatloaf, garlic mashed potatoes, Italian vegetable blend, wheat dinner roll, fruit cobbler, milk, and hot tea were to be served. -On Saturday, baked herb pollock, stuffed cabbage roll, roasted thyme gold potatoes, California vegetable blend, peanut butter cookie, wheat dinner roll, milk and hot tea were to be served. -On Sunday, ham steak, baked chicken, mushroom bread dressing, spinach, wheat dinner	D 285		

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D 285	Continued From page 34 roll, apricot parfait, milk, and hot tea were to be served. Review of the facility's dinner menu for 1 week revealed: -On Monday, broccoli cheese soup, saltine crackers, Italian beef sandwiches, spinach Florentine, tomato barley risotto, sauteed peppers and onions, wheat dinner roll, rocky road pudding, milk, and hot tea were to be served. -On Tuesday, pasta fagioli soup, saltine crackers, cheese strata, turkey Santa Fe, sweet potato wedges, spinach, wheat dinner roll, fruit parfait, milk and hot tea were to be served. -On Wednesday, Red pepper potato soup, saltine crackers, ham and Swiss wrap, beef with vegetables, Greek pasta salad, cucumber sour cream salad, wheat dinner roll, cheesecake, milk and hot tea were to be served. -On Thursday, tomato bisque, saltine crackers, vegetable pasta primavera, grilled chicken breasts, confetti rice salad, toss salad with dressing, garlic parmesan bread, apple betty, milk and hot tea were to be served. -On Friday, corn chowder, saltine crackers, stuffed tomato with turkey salad, breaded veal cutlet, herb lemon butter sauce, tri color pasta salad, sugar snap peas, wheat dinner roll, lime dream cake, milk and hot tea were to be served. -On Saturday, zesty bean soup, saltine crackers, broccoli cheese souffle, chicken club sandwich, onion rings, cauliflower, biscuit, blushing pears, milk, and hot tea were to be served. -On Sunday, savory summer soup, saltine crackers, mambo pork loin, baked popcorn shrimp, roasted rosemary potato wedges, pickled beet and onion salad, wheat dinner roll, pineapple with strawberries, milk and hot tea were to be served.	D 285		

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D 285	Continued From page 35 Interview with the Dietary Manager on 07/29/26 at 2:08pm revealed: -She knew the facility needed to have a 3-day supply of perishable and 5-day supply of non-perishable food items available to be served. -She knew there was not a 3-day supply of perishable and 5-day supply of non-perishable food items to be served to the residents. -She entered the food order into the computer, the food order then went to the corporate office to approve. -When her food order arrived, most of the food she ordered would not be delivered. -She was not sure if someone from corporate or if the food delivery company changed the food order. -The facility was getting more admissions, but her food budget was not changing. -She ordered what she could to make sure the residents had food to eat. -She was concerned that if there was an emergency, she would not have enough food to provide to the residents. Interview with the Administrator on 07/30/26 at 5:15pm revealed: -She knew the facility needed to have a 3-day supply of perishable and 5-day supply of non-perishable food items available to be served. -She did not know there was not enough food for a 3-day supply of perishable and 5-day non-perishable food supply. -She went into the kitchen approximately 1-2 weeks ago to look for cleanliness of the dry food storage, freezer and cooler. -The Dietary Manager was responsible for the food supply order.	D 285		

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D 292	Continued From page 36	D 292		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain a record of menu substitutions documenting what was served to residents. The findings are: Review of the daily menu for 07/28/26 revealed: -The lunch meal listed Asian barbeque turkey, baked tilapia, lemon risotto, oven roasted vegetables, wheat dinner roll, and chocolate pudding torte were to be served. -The dinner meal listed a pasta fagioli soup, saltine crackers, cheese strata, turkey Santa Fe, sweet potato wedges, spinach, wheat dinner roll, and fruit parfait were to be served. Observation of the lunch meal on 07/28/26 at	D 292	The facility reviewed the menu and menu substitution process. The menu substitution log was corrected and implemented to ensure that whenever a food item is substituted, the substitution is of appropriate nutritional value and the food actually served to residents is accurately documented. The Executive Director completed an ~~of~~ audit of the facility's menus and menu substitution records to ensure that substitutions were being properly documented and that the records accurately reflected the foods served to residents. The new Dietary Manager and	8-24-26

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D 292	Continued From page 37 12:00pm revealed the residents were served a slice of barbeque turkey, stuffing, canned mixed vegetables, a sliced of wheat bread, and fruit cocktail. Observation of the dinner meal on 07/28/26 at 5:17pm revealed the residents were served a chicken drumstick, sliced carrots, boiled potatoes, a wheat roll, fruit cocktail or a cookie. Review of the item substitution log on 07/29/26 at 12:32pm -There was a column for the date of the food substitution, a column for the food item that was to be served and a column for the food substitution. -There was stuffing listed as substituted for lemon risotto on 07/28/26. -There was no other food substitutions listed. Review of the daily menu for 07/29/26 revealed: -The breakfast meal listed cream of rice, banana, Belgian waffle, fruit compote, and a sausage patty were to be served. -The lunch meal listed baked thyme chicken, pot roast, oven browned potatoes, summer squash, wheat dinner roll, and apple crisp were to be served. -The dinner meal listed red pepper potato soup, saltine crackers, ham and swiss wrap, beef with roasted vegetables, Greek pasta salad, cucumber sour cream salad, wheat dinner roll, and cheesecake were to be served. Observation of the breakfast meal on 07/29/26 at 8:20am revealed the residents were served scrambled eggs, oatmeal, sausage patty, sliced bread, and fresh orange slices. Observation of the lunch meal on 07/29/26 at	D 292	dietary staff were educated on following the facility's approved menus and properly documenting all menu substitutions. Staff were instructed that when a menu item is unavailable or a substitution is necessary, the replacement must be of appropriate nutritional value and documented on the menu substitution log at the time the substitution is made. The Dietary Manager will be responsible for reviewing the daily menus and substitution logs to ensure that all substitutions are properly documented	

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D 292	Continued From page 38 12:15pm revealed the residents were served hotdog's, chips, coleslaw, watermelon and a cookie. Observation of the Dietary Manager(DM) and a cook on 07/29/26 at 2:32pm revealed: -The DM asked the cook what she was serving the residents for dinner. -The cook did not know what she was serving the residents for dinner that evening. -The cook picked items they had available to come up with a meal to serve for dinner. Observation of the dinner meal on 07/29/26 at 5:15pm revealed the residents were served potato soup, a ham sandwich, pasta salad and a cupcake. Review of the item substitution log on 07/29/26 at 12:32pm -There were hotdog's listed as substituted for beef and gravy on 07/29/26. -There was no other food substitutions listed. Interview with the dietary manager (DM) on 07/30/26 at 8:45am revealed: -They had a weekly menu that was divided into the days of the week. -Each day of the week had what they were to serve the residents for that day. -They did not serve the residents what was listed under each day of the week. -They pick items from the entire weekly menu to put a meal together to serve that day. -They would cross items off the weekly menu as they used them. -The beef gravy was on the weekly menu to be served for lunch on Wednesday that week; they had a birthday party on 07/29/26 and changed the menu to hotdog's.	D 292	and accurately reflect the foods served to residents The Executive Director will conduct periodic audits of the menus and substitution logs to verify Continued Compliance. Any identified Concerns will be corrected immediately, and additional staff education will be provided as necessary.	

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D 292	Continued From page 39 -She did not realize she had to put every item that was substituted on the substitution log. Interview with the Administrator on 07/30/26 at 5:15pm revealed: -The cooks should follow the regular cycled weekly menu. -The cooks should document everything they substituted on the substitution log.	D 292		
D 294	10A NCAC 13F .0904(c)(5) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (5) Menus as served, invoices, and other receipts for food or beverage purchases shall be maintained in the facility for 30 days. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain food invoices for 30 days. The findings are: Review of the food invoices for the facility revealed: -There was a food invoice dated 06/30/26. -There were no other food invoices available for review.	D 294	The facility implemented a system to ensure that all food invoices and receipts for food and beverage purchases are maintained at the facility for a minimum of 30 days. A designated binder/file has been established for the retention and organization of all food invoices and receipts The Executive Director reviewed the available dietary records and food invoices to ensure that all currently available invoices and	8.24.26

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D 294	Continued From page 40 Interview with the Dietary Manger (DM) on 07/29/26 at 2:08pm revealed: -She discarded the food invoices after she reviewed the order. -She was not sure why she still had the food invoice from 06/30/26. -She did not know she had to keep the food invoices for 30 days. Interview with the Administrator on 07/30/26 at 6:20pm revealed she did not know the food invoices should be kept for 30 days.	D 294	receipts were Properly filed and maintained in the designated location. The new Dietary Manage was educated regarding the requirement to maintain menus asserved, food invoices, and other receipts for at least 30 days. The Dietary manage Instructed not to discard invoice or receipts for 30 days. The Dietary Manager will be responsibe for ensuring that all food invoices and receipts are placed in the designated binder/file. The Executive Director will Conduct periodic audits of the dietary records to verify that invoices and receipts are present, organized, and maintained for at least 30 days.	
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, record reviews, and interviews, the facility failed to have matching therapeutic diet menus for 1 of 5 sampled residents (#2) who had a physician order for finger foods with double portions. The findings are: Review of Resident #2's current FL-2 dated	D 296		

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D 296	Continued From page 41 08/01/25 revealed: -Diagnoses included dementia. -There was no diet order. Review of Resident #2's diet order dated 03/12/26 revealed an order for finger foods and double portions. Review of the facility's therapeutic diet binder revealed Resident #2 had an order for finger foods and double portions. Review of the facility's menus revealed there were no therapeutic diet menus that matched what was being served for finger food with double portions available for review. Observation of the lunch meal service on 07/28/26 between 11:57am and 12:30pm revealed: -Resident #2 was served a slice of turkey, a plain baked potato cut in 4 pieces, stuffing, 1 slice of bread, mixed vegetables, and a bowl of fruit cocktail. -Staff assisted Resident #2 with eating her meal by feeding her from a fork and spoon. -Resident #2 ate 100% of his meal. Based on observation of the lunch meal service on 07/28/26, it could not be determined if Resident #2 was served the appropriate therapeutic diet due to no finger food and double portions diet menu available for staff guidance. Interview with a personal care aide (PCA) on 07/28/26 at 12:02pm revealed: -She did not think Resident #2 was served finger foods for lunch. -She thought Resident #2 would make a mess and not eat her meal.	D 296	Resident # 2 dietary needs were reassessed and the physician's diet order was updated. Resident # 2 previous order for finger foods with double portions was discontinued and changed to a regular diet. Staff will provide feeding assistance as needed Resident # 2 diet information, care plan, and applicable dietary records were updated to reflect the new physician order and current level of assistance required The Executive Director completed an audit of residents with physician-ordered diets to ensure current diet orders were	

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D 296	Continued From page 42 -She thought Resident #2 would not be able to feed herself, so she fed her the meal. Interview with a medication aide (MA) on 07/30/26 at 3:31pm revealed: -She did not think Resident #2 was served finger foods. -Resident #2 was not served double portions. -Resident #2 would not know how to pick up a fork or spoon to feed herself. -When Resident #2 was not served finger foods the staff would feed her. Interview with a cook on 07/28/26 at 2:10pm revealed: -She did not know where the therapeutic diet menu was. -She called the Dietary manager (DM) to ask where it was. -The DM did not know where it was but would call the Administrator to have her print a new one. -She used a weekly menu to prepare the meals for the residents. Interview with the Dietary Manager (DM) on 07/29/26 at 2:08pm revealed: -The DM did not know where the therapeutic diet menu was. -She asked the Administrator to print a new therapeutic diet menu. -The therapeutic diet menu the Administrator printed did not match the weekly menu they used to prepare meals for the residents. -She was not sure why the therapeutic diet menu did not match the weekly menu. -When a resident had a finger food diet the dietary staff would just pick food from the weekly menu that could be picked up with the hands. Interview with the Administrator on 07/30/26 at	D 296	accurately reflected in the residents records and communicated to dietary and direct-care staff Any discrepancies identified during the audit were Corrected. The new Dietary Manager and dietary Staff were educated regarding the importance of following each resident current physician-ordered diet and ensuring that dietary information is updated whenever a new or changed diet order is received. Direct-care staff were also educated on following residents current feeding-assistance needs. The Dietary manger will be responsible for ensuring	

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D 296	Continued From page 43 6:20pm revealed: -The DM was responsible for ensuring the resident was served the correct therapeutic diet. -There should have been a therapeutic diet menu in the kitchen for the DM to follow. -She printed a therapeutic diet menu for the kitchen staff on 07/28/26. -She did not know the therapeutic diet menu did not match what the kitchen staff used to prepare the residents' meals. Based on observations, record review and interviews, it was determined that Resident #2 was not interviewable.	D 296	That current Physician-Ordered diets are accurately communicated and followed. The RCC will ensure residents care Plans and feeding-assistance needs are updated when changes occur. The Executive Director will conduct periodic audits of diet orders.	
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, record reviews, and interviews, the facility failed to clarify a medication order for 1 of 5 sampled residents (#2) related to	D 344	Resident #2 medication order was reviewed and clarified with the prescribing Provider. The medication order and eMAR were corrected to reflect the clarified Physician's order. The resident's medication record was reviewed to ensure medications were being administered according to current physician orders. MA and RCC were re-educated regarding medication orders	8-1-26

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D 344	Continued From page 44 an order for a medication used to treat allergy symptoms. The findings are: Request for the facility's Medication Administration Policy on 07/29/26 was not provided by survey exit. Review of Resident #2's current FL2 dated 08/01/25 revealed diagnoses included dementia, diabetes mellitus type 2 and depression. Review of Resident #2's physician's orders dated 03/06/26 revealed an order for fexofenadine (used to treat allergy symptoms) 180mg, take 1 tablet daily. Review of Resident #3's pharmacy review dated 06/22/26 revealed: -There was a recommendation to decrease Resident #2's fexofenadine from 180mg to 60mg every 12-24 hours due to declining kidney function. -The Primary Care Provider (PCP) signed the recommendation on 06/25/26. Review of Resident #2's June 2026 electronic medication administration record (eMAR) from 06/25/26-06/30/26 revealed: -There was an entry for fexofenadine 180 mg once daily with a scheduled administration time of 9:00am. -There was documentation fexofenadine was administered daily from 06/25/26-06/30/26. Review of Resident #2's July 2026 eMAR from 07/01/26-07/28/26 revealed: -There was an entry for fexofenadine 180 mg once daily with a scheduled administration time of	D 344	requirements. Staff were instructed that all medication orders must be clear and complete and that any order containing an unclear administration range or conflicting directions must be clarified with the prescribing provider before administration. MA were also re educated to review the complete medication order and directions and not rely solely on the barcode scanner or eMAR alerts when administering medications. The RDC will routinely audit medication orders and eMARS to ensure orders are clear, complete, and accurately transcribed and that medication are administered according to the Prescribing Providers orders	

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D 344	Continued From page 45 9:00am. -There was documentation fexofenadine 180 mg was administered daily from 07/01/26-07/08/26. -There was a second entry for fexofenadine 60mg take 1 tablet every 12-24 hours with a scheduled administration time of 9:00am and 7:00pm. -There was documentation fexofenadine 60mg was administered twice daily from 07/09/26-07/28/26. Observation of Resident #2's medications on hand on 07/28/26 at 3:54pm revealed: -There was a punch card labeled for fexofenadine 60mg with a dispense date of 07/13/26. -The directions on the label were to take 1 tablet every 12 -24 hours. -There were 62 tablets dispensed, and 47 tablets remained on the punch card. Telephone interview with a representative from the facility's contracted pharmacy on 07/29/26 at 12:15pm revealed: -Resident #2's current order was fexofenadine 60mg, take 1 tablet every 12-24 hours and was received on 07/08/26. -There was no note in their system the pharmacy called the facility or the PCP to clarify the order administration range of 12-24 hours. -There were no notes in their system the facility called to clarify the fexofenadine order. -Fexofenadine 60mg was dispensed on 07/08/26 with a quantity of 14 to last until the medication cycle fill on 07/15/26. Interview with the Special Care Unit Coordinator (SCC) on 07/30/26 at 4:10pm revealed: -She did not notice the administration time range of 12-24 hours on Resident #2's fexofenadine. -During medication pass, she scanned the	D 344		

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D 344	Continued From page 46 medication's barcode and if the eMAR did not alert an error she administered the medication as it was entered onto the eMAR. -She did not read the medication administration directions for fexofenadine. -She knew medications could not have ranges written in the order. -If she had noticed the range, she would have called the PCP to clarify the order. Interview with the Resident Care Coordinator (RCC) on 07/30/26 at 5:19pm revealed: -The previous RCC was responsible for reviewing the pharmacy recommendations and orders in June 2026. -Any order that was written with a range should be clarified with the PCP. -She had told the MAs not to rely on using the scanner when passing medications but to read the directions as well. -She expected the MAs to read the order and notified the PCP for clarification on the range in the order. Interview with the Administrator on 07/30/26 at 6:20pm revealed she expected any order with ranges to be clarified with the PCP. Attempted telephone interview with Resident #2's PCP on 07/30/26 at 12:08pm and 4:24pm was unsuccessful.	D 344		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments	D 358	Resident #2 medication and treatment orders were reviewed to ensure accuracy	7-31-26

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D 358	Continued From page 47 by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#2) including an antifungal cream. The findings are: Request for the facility's Medication Administration Policy on 07/29/26 was not provided by survey exit. Review of Resident #2's current FL2 dated 08/01/25 revealed diagnoses included dementia, diabetes mellitus type 2 and depression. Review of Resident #2's physician's order dated 03/06/26 revealed an order for ciclopirox (an antifungal cream) 0.77%, apply to both feet twice daily. Review of Resident #2's electronic medication administration record (eMAR) for May 2026 revealed: -There was an entry for ciclopirox apply to both feet twice daily with a scheduled administration time of 9:00am and 7:00pm. -There was documentation ciclopirox was administered twice daily from 05/01/26-05/31/26. Review of Resident #2's eMAR for June 2026 revealed: -There was an entry for ciclopirox apply to both feet twice daily with a scheduled administration	D 358	and compliance. The ciclopirox order was reviewed and the medication is being administered as ordered. The resident's medication administration record was updated as appropriate to reflect the current physician's orders. All MA and RCCWE re-educated regarding Proper medication and treatment administration and documentation. Staff were instructed that medications and treatments must be administered according to the physicians order and must not be documented as administered unless they were actually given. Staff were also re-educated on proper procedures for resident refusals including	8-6-26

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D 358	Continued From page 48 time of 9:00am and 7:00pm. -There was documentation ciclopirox was administered twice daily from 06/01/26-06/30/26. Review of Resident #2's eMAR for July 2026 from 07/01/26-07/28/26 revealed: -There was an entry for ciclopirox apply to both feet twice daily with a scheduled administration time of 9:00am and 7:00pm. -There was documentation ciclopirox was administered twice daily from 07/01/26-07/28/26. Observation of medications on hand for Resident #2 on 07/28/26 at 3:56pm revealed: -There was a box labeled ciclopirox cream 0.77%, apply to feet twice daily with a fill date of 06/26/26; the box contained an unopened tube of ciclopirox. -There was a second box labeled ciclopirox cream 0.77%, apply to feet twice daily with a fill date of 07/21/26; the box contained an unopened tube of ciclopirox. Observation of medications on hand for Resident #2 on 07/30/26 at 5:05pm revealed there was a box labeled ciclopirox cream 0.77%, apply to feet twice daily with a fill date of 01/21/26; the box contained an open tube of ciclopirox that was half full. Telephone interview with a representative from the facility's contracted pharmacy on 07/29/26 at 12:15pm revealed: -Long term use of ciclopirox would be used to prevent fungal infections. -The pharmacy dispensed ciclopirox on 01/21/26, 06/26/26, and on 07/21/26. -A tube of ciclopirox would last between 4 and 6 weeks depending on how much was applied. -Ciclopirox was not on a medication cycle, so the	D 358	documentation and appropriate notification. MAI involved in the identified Concerns received Corrective action! The RCC will conduct ongoing audits of medication and treatment administration records to verify that medications and treatments are administered and documented according to physician orders. The RCC will be responsible for ongoing monitoring of medication administration and documentation. The Executive Director will Provide oversight to ensure continued Compliance with 10A NCAC 13F. 1604(a)	

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D 358	Continued From page 49 facility needed to request a refill. -If ciclopirox was not administered as ordered, Resident #2 would be at risk for fungal infections. Interview with a medication aide (MA) on 07/30/26 at 2:57pm revealed: -She applied Resident #2's ciclopirox cream as ordered. -She did not realize the only open tube of ciclopirox was dispensed in January 2026. -She did not notice there were 2 unopened tubes of ciclopirox on the medication cart. Interview with a second MA on 07/30/26 at 3:31pm revealed: -She knew Resident #2 had an order to apply ciclopirox cream to her feet twice daily. -She did not always administer ciclopirox because Resident #2 would get agitated. -She was the only MA on second shift for the entire building and would get busy, so she did not always administer Resident #2's ciclopirox. -She would document she administered Resident #2's ciclopirox because she was rushed and just clicked administered on the eMAR. Interview with the Special Care Unit Coordinator (SCC) on 07/30/26 at 4:10pm revealed: -She often administered medications to the residents in the SCU. -She noticed Resident #2 had a tube of ciclopirox from January 2026 and thought she discarded it. -She ordered another tube of ciclopirox from the pharmacy last week sometime. -She did not remember seeing 3 tubes of ciclopirox on the medication cart. -She did not realize the only open tube of ciclopirox was dispensed in January 2026. -She must have administered Resident #2 ciclopirox from the tube dispensed in January	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039016	A. BUILDING: _____ B. WING _____	R 07/30/2026

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D 358	Continued From page 50 2026. Interview with the Resident Care Coordinator (RCC) on 07/30/26 at 5:19pm revealed: -Resident #2 could be hesitant to have the ciclopirox applied to her feet but she would eventually let the MAs apply it. -She noticed a tube of ciclopirox on the medication cart from January 2026 and thought it was discarded. -With 2 unopened tubes of ciclopirox and 1 opened tube that was dispensed in January 2026 on the medication cart suggested that Resident #2's ciclopirox was not administered as ordered. -She expected the MAs to administer ciclopirox as ordered. Interview with the Administrator on 07/30/26 at 6:20pm revealed she expected Resident #2's ciclopirox to be administered as ordered. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Attempted telephone interview with Resident #2's PCP on 07/30/26 at 12:08pm and 4:24pm was unsuccessful.	D 358		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.	D 371	All MA re-educated on Proper Infection-Control Practices during medication administration, including	8-6-26

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D 371	Continued From page 51 This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure infection control measures were implemented during the morning medication pass by a medication aide (MA) who did not wash or sanitize her hands between the preparation and administration of medications to each resident. The findings are: Request for the facility's policy for Medication Administration was not provided by survey exit. Observation of the MA during the medication pass on 07/29/26 between 8:20am and 8:45am revealed: -The MA walked to the medication cart from administering medication to a resident. -She unlocked the medication cart with keys. -She touched the electronic medication administration record (eMAR), opened the medication drawer and began to scan the medication cards and poured medications without sanitizing her hands. -There was hand sanitizer on the medication cart. -She poured 7 oral medications for a resident along with a cup of water. -She locked the medication cart. -She took the medication cup that contained 7 oral medications to a resident in his room, handed the resident the medication cup and cup of water, and observed the resident swallow the medications. -The MA took the empty cup of medications and empty cup of water and disposed of them in the bathroom trash can.	D 371	performing appropriate hand hygiene before preparing medications and between each resident medication administration. Staff were reminded to use hand sanitizer when appropriate and soap and water when required. The RCC will conduct random medication-pass observations weekly for 4 weeks and monthly after. Any identified concerns will be corrected immediately and additional education or corrective action will be provided as necessary. The RCC will be responsible for staff	

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D 371	Continued From page 52 -She walked back to the medication cart without washing her hands. -She documented on the resident's eMAR without sanitizing her hands. Interview with the MA on 07/29/26 at 9:00am revealed: -She washed her hands before starting her medication pass. -She had hand sanitizer on her cart and knew to use it in between each resident. -She did not remember that she did not sanitize or wash her hands between residents. Telephone interview with the facility's primary care provider (PCP) on 07/30/26 at 12:50pm revealed: -The MAs should wash or sanitize their hands between passing medications to each resident. -Not washing hands with soap and water or using hand sanitizer put the residents and employees at risk for the spread of infections. Interview with the Resident Care Coordinator (RCC) on 07/30/26 at 5:23pm revealed: -Hand sanitizer was available on each medication cart. -MAs should use proper hygiene by using hand sanitizer before pouring medications and after administering medication to residents. -MAs should use soap and water to clean hands after blood contact. -MAs went through re-education yearly and proper administration of medications and hygiene were taught each year. -She was concerned that the MA did not wash her hands between administering medications to residents. Interview with the Administrator on 07/30/26 at 6:27pm revealed:	D 371	education, medication pass observations, documentation of monitoring and ensuring continued compliance with infection-control requirements	

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D 371	Continued From page 53 -Handwashing prior to pouring and after administering medication should be done. -There was a concern that the MA did not wash her hands before pouring medications after leaving the resident's room.	D 371		