STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092235	A. BUILDING: _____ B. WING _____	08/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER COURT	1130 FALLS RIVER AVENUE RALEIGH, NC 27614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on August 19, 2026 through August 21, 2026.	D 000	Prefix Tag D 611 Corrective Action: All direct-care team members involved with feeding assistance or assist residents during mealtimes will be educated on infection control principles, with specific emphasis on appropriate hand hygiene and the requirement to perform hand sanitization between assisting each resident. Education will reinforce that hand hygiene is required regardless of whether the team member is assigned as a scheduled feeder or is aiding on an as-needed basis. Hand Sanitizer is readily available in multiple locations for team members. Education will be completed by September 24, 2026, and will be provided by a RN Consultant Shirley T. McNeil, RN, BSN. Monitoring: Following completion of education, observations of resident mealtime assistance will be conducted to support hand hygiene requirement.	
D 611	10A NCAC 13F .1801(b) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following: (1) Standard and transmission-based precautions, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or	D 611		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Rueyinger — TITLE: Executive Director — (X6) DATE: 9/11/2026

Received and Acknowledged on 2026-09-11 by NURSE CONSULTANT Shirley B. Nielsen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092235	A. BUILDING: _____ B. WING _____	08/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER COURT	1130 FALLS RIVER AVENUE RALEIGH, NC 27614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 611	Continued From page 1 restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control practices of hand hygiene were observed during assistance in feeding residents during a meal. The findings are: Review of the facility's Hand Hygiene Policy and Procedure dated 08/2019 revealed: -Effective hand hygiene reduced the incidences of healthcare associated infections. -Staff were to wash their hands before and after eating and before or after any procedure. Observation in the dining room during breakfast meal service on 08/20/26 between 7:53am and 9:00am revealed: -A personal care aide (PCA) was seated to the right of a resident at a table in the dining room.	D 611	Observation schedule as follows: •Three times weekly for three consecutive weeks •If no additional findings are identified, monitoring will decrease to two times weekly for two consecutive weeks. •If no additional findings are identified, monitoring will then continue through random observations for an additional two weeks to ensure sustained compliance. Responsibility: •Monitoring observations will be conducted by the Care Directors, Resident Care Director or Designee. •The Executive Director will review and monitor the completed observation/audits to support observations are occurring as scheduled and that identified concerns are appropriately addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092235	A. BUILDING: _____ B. WING _____	08/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER COURT	1130 FALLS RIVER AVENUE RALEIGH, NC 27614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 611	Continued From page 2 -The plate on the table in front of the resident had pureed foods in different bowls on a plate. -The PCA was feeding the resident. -The PCA got up and went to another table and cut up a resident's food and encouraged the resident to eat. -The PCA returned the table to continue feeding the first resident. -The PCA later got up and went to another table and cut up French toast for another resident and encouraged the resident to eat. -The PCA returned to the table to continue feeding the first resident. -The PCA did not sanitize her hands between handling of the first resident and the other residents' silverware. -After assisting the resident she was feeding from the dining room, the PCA went to both residents she had cut up food for and tried to encourage them to eat by picking up a piece of food with the fork. -The PCA did not sanitize her hands between assisting the 2 residents. Interview with the PCA on 08/20/26 at 2:49 revealed: -She was responsible for providing feeding assistance to residents. -If a staff member was providing feeding assistance to more than one resident, the staff member was supposed to sanitize their hands between assisting each resident. -Staff was not supposed to assist more than one resident at a time in the dining room. -She assisted 2 other residents in the dining room to encourage them to eat. -She did not sanitize between the 3 residents in the dining room today, 08/20/26, because the only available sanitizer was on the medication cart.	D 611	Responsibility Cont.: If a hand hygiene deficiency is identified during monitoring, immediate corrective education will be provided to the team member, and the finding will be documented. Additional monitoring and education will be implemented as indicated until sustained compliance is demonstrated. Audits will be available upon request. Completion date of plan of correction is September 25, 2026.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092235	A. BUILDING: _____ B. WING _____	08/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER COURT	1130 FALLS RIVER AVENUE RALEIGH, NC 27614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 611	Continued From page 3	D 611		

-She did not tell anyone she needed hand sanitizer.
-She sanitized her hands before returning to the dining room after taking the first resident out of the dining room.
-She received training on feeding assistance and hand hygiene in 2025.

Interview with a second personal care aide (PCA) on 08/20/26 at 2:41pm revealed:
-She was responsible for providing feeding assistance to residents.
-She washed/sanitized her hands between each interaction.
-She washed her hands before entering the dining room.
-She kept a small bottle of hand sanitizer in her pocket.
-She never assisted another resident while providing feeding assistance.
-Training regarding feeding assistance was provided upon hire and every other month.
-Washing/sanitizing hands between residents was done to prevent the spread of germs.

Interview with a medication aide (MA) on 08/20/26 at 2:06pm revealed:
-She was working as a PCA.
-She assisted residents with feeding in the dining room.
-When providing feeding assistance, staff were not to feed or assist any other residents.
-Staff were to wash or sanitize their hands in between assisting residents in the dining room.
-Washing/sanitizing hands between assisting residents in the dining room prevented sanitation issues.
-Staff were trained on feeding assistance and hand hygiene upon hire.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092235	A. BUILDING: _____ B. WING _____	08/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER COURT	1130 FALLS RIVER AVENUE RALEIGH, NC 27614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 611	Continued From page 4	D 611		

Interview with a second MA on 08/21/26 at 11:53am revealed:
-When providing feeding assistance to residents, staff were to sanitize their hands prior to assisting.
-Staff were not supposed to assist more than one resident at a time to avoid cross contamination.
-Training on feeding assistance and hand hygiene was provided upon hire as well as yearly through online courses or a trainer.

Interview with the facility's contracted primary care provider (PCP) on 08/20/26 at 3:10pm revealed:
-Staff were expected to sanitize their hands between resident interactions in the dining room.
-Staff not sanitizing their hands while providing feeding assistance caused infection control concerns.

Interview with the Wellness Director (WD) on 08/20/26 at 3:35pm revealed:
-The PCAs and MAs were responsible for providing feeding assistance to residents.
-When providing feeding assistance, the staff sat one on one with the residents.
-Feeding assistance was provided with one staff per resident.
-It was expected that the staff members washed their hands before going into the dining room and after feeding the resident.
-Staff wanted to help other residents if the residents did not need feeding assistance but needed encouragement.
-Failure to sanitize between residents could have led to the spread of bacteria.
-There were small bottles of hand sanitizer in the supply closet that were recently ordered.
-Staff members had been using the hand sanitizer on the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092235	A. BUILDING: _____ B. WING _____	08/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER COURT	1130 FALLS RIVER AVENUE RALEIGH, NC 27614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 611	Continued From page 5 -The PCAs had access to the hand sanitizer on the medication cart. -Training was provided by the human resources department; she was unsure what training staff received. Interview with the Administrator on 08/20/26 at 3:46pm revealed: -PCAs and MAs were responsible for providing feeding assistance to residents. -Staff were expected to sanitize their hands before and after providing feeding assistance. -Staff should not be touching other residents' utensils and if they did so, they should have washed or sanitized their hands. -Staff should be sitting with the resident they were providing assistance to at all times. -All staff received hand hygiene training (unsure when). -She was unsure if staff received hand hygiene with feeding assistance training. -Failure to sanitize when providing feeding assistance could have led to the spread of communicable diseases.	D 611		