STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

(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 a follow-up survey and complaint investigation on February 11, 2025 through February 13, 2025.	D 000		
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: FOLLOW-UP TO TYPE A1 VIOLATION. The Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 5 sampled residents (#1, #2) including failing to coordinate wound care for a resident with diabetes (#1) and failing to coordinate obtaining blood levels as ordered for a medication used to treat and prevent seizures (#2). The findings are: 1. Review of Resident #1's current FL-2 dated 01/16/25 revealed: -Diagnoses included type 2 diabetes mellitus, chronic kidney disease stage 3, and hypertension. -The resident required assistance with bathing and dressing.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

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D 273	Continued From page 1	D 273		

-The resident was documented as intermittently disoriented.
-The resident was semi-ambulatory and incontinent of bladder.

Review of Resident #1's Resident Register revealed:
-The resident was admitted to the facility on 02/09/24.
-The resident required assistance with dressing, bathing, ambulation, toileting, hair/grooming, and skin care.
-The resident's memory was documented as adequate.
-The resident used a wheelchair.

Review of Resident #1's current assessment and care plan dated 03/18/24 revealed:
-The resident required supervision by staff with eating.
-The resident required limited assistance by staff with toileting, ambulation, dressing, grooming, and transferring.
-The resident required extensive assistance by staff with bathing.

Review of Resident #1's resident care notes dated 01/29/25 revealed:
-The resident had a small wound on her lower mid-back.
-The medication aide (MA) applied antibiotic ointment and a bandaid.

Review of Resident #1's electronic charting notes dated 02/01/25 at 1:24pm revealed:
-Resident #1 called the MA into her room and told the MA that her lower back was in pain.
-The small of the resident's lower back was open and red and causing the resident pain.
-The MA sent the on-call provider a picture of it,

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	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

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D 273	Continued From page 2 as well as the Executive Director (ED). Interview with a MA on 02/13/25 at 11:12am revealed: -On Saturday, 02/01/25, Resident #1 called the MA to the resident's room. -The resident told the MA there was something wrong with her back. -When she looked at the resident's back, she saw a wound. -She took a picture of the wound and sent it to the ED. -The ED instructed her to call the on-call provider and send a picture of the wound to the on-call provider. -She spoke with an on-call provider who gave a phone number for the MA to send a picture of the wound. -She did not hear back from the on-call provider. -She did not call the on-call provider back or resend the picture because she was just waiting for something to come through via fax. -She never called the on-call provider back because the facility's contracted primary care provider (PCP) would be coming to the facility on the following Thursday. -She did not notify the facility's contracted PCP about the resident's wound and she did not know if the resident was seen by the PCP on that Thursday. Observation of a cell phone picture of Resident #1's wound on 02/13/25 at 9:19am revealed: -There was a picture of Resident #1's wound on her back on the MA's cell phone. -The picture was dated Saturday, 02/01/25 at 12:44pm. -There was a dime-sized open area on the resident's lower mid-back with pink tissue around the edges and some dried yellow crust outside	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

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D 273	Continued From page 3	D 273		

the margins of the wound.
-There was no drainage or pus coming from the wound.

Interview with the Office Manager on 02/13/25 at 8:48am revealed:
-She had not seen the wound on Resident #1's back because she had not been made aware of it.
-The MAs should have reported it to her or the ED or both of them.

Interview with Resident #1 on 02/13/25 at 9:02am revealed:
-She was diabetic and she had a history of non-healing wounds in the past on her hip area.
-The wound on her mid-lower back had been hurting for about 3 weeks.
-She could not sleep lying on her back because of the pain from the wound.
-She first reported it to facility staff a couple of weeks ago but they did not do much about it.
-When she was taking a shower a couple of weeks ago, the personal care aide (PCA) let the MA know the wound was open.
-She thought the MA just put a bandaid on it at that time and called the on-call provider and the ED because the wound was "really hurting".
-She was not sure if the on-call provider ever called back.
-The ED had not been in to check on the wound.

Observation of Resident #1 on 02/13/25 at 9:09am revealed:
-There was a clear plastic bandage on top of a wound on the resident's lower mid-back.
-The Office Manager removed the bandage.
-There was a dime-sized open area on the resident's lower mid-back.
-There was a red band of tissue around the

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	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

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SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

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D 273	Continued From page 4	D 273		

edges of the open wound.
-The was yellow drainage around the wound and thick yellow pus coming from the middle of the wound.
-The wound had a foul, pungent odor.

Interview with the ED on 02/13/25 at 9:42am revealed:
-She was out sick last week when a MA sent a picture of a wound on Resident #1's back to her cell phone.
-The picture was sent to her cell phone on Saturday, 02/01/25 at 12:44pm.
-She responded to the MA and told the MA to contact the on-call provider and send a picture of the wound to the on-call provider.
-The on-call provider was not picking up, so she told the MA if they did not call back to retry contacting the on-call provider the next day.
-She did not hear back from the MA or the on-call provider about the resident's wound.
-No one reported to her that the wound was still a problem when the ED returned to work this week.
-She did not think about checking the resident's wound when she returned to work this week because she had no other reports about it.
-If the first MA did not hear back from the on-call provider, she should have told the oncoming MA to follow-up and call back.
-The PCAs were responsible for reporting changes in condition to the MAs and the MAs were responsible for reporting it to the her or the Office Manager.

Second interview with the Office Manager on 02/13/25 at 9:46am revealed:
-No facility staff had reported Resident #1's back wound to her.
-She called the on-call provider today, 02/13/25, because the facility's contracted PCP was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

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D 273	Continued From page 5	D 273		

unavailable.
-The on-call provider gave an order for home health to evaluate and treat the wound and an order for a wound culture.
-The on-call provider ordered a wound culture so she would know which antibiotic (used to treat infections) needed to be ordered.

Telephone interview with an on-call provider from the facility's contracted PCP's office on 02/13/25 at 3:44pm revealed:
-Resident #1's PCP was unavailable for interview today.
-She was not on-call on 02/01/25.
-There was a note that another on-call provider received a call about Resident #1's open area on her lower back on 02/01/25.
-The other on-call provider noted an order was given for wound care for further evaluation.
-It may have been a verbal order; she was not sure.
-She gave orders today, 02/13/25, for home health to evaluate and treat the wound and for a wound culture.
-She also gave an order for Triple Antibiotic Ointment to be applied twice a day until the culture results came back.
-Resident #1 was diabetic so a delay in treating the wound could cause infection and lead to sepsis (a potentially life-threatening condition caused by infection).
-There was also a potential that the wound could be worse than what could be seen with the eye (referring to a deeper wound).

2. Review of Resident #2's current FL-2 dated 01/16/25 revealed:
-Diagnoses included epilepsy (seizure disorder), hypertension, history of thrombosis, benign prostatic hypertrophy, insomnia,

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	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

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D 273	Continued From page 6	D 273		

gastroesophageal reflux disease, and schizophrenia.
-The resident was documented as intermittently disoriented.
-The resident was ambulatory.
-The resident required assistance with bathing and dressing.
-There was an order for Keppra 1,000mg take 2 tablets twice a day. (Keppra is a medication used to treat and prevent seizures. Keppra blood levels may be checked to ensure the medication is in therapeutic range and to help prevent underdosing or toxic levels.)

Review of Resident #2's hospital emergency room (ER) form dated 01/09/25 revealed the resident was seen for and diagnosed with a breakthrough seizure.

Review of Resident #2's primary care provider (PCP) order dated 01/09/25 revealed the resident had recurrent seizures and there was an order to check the resident's Keppra level.

Review of Resident #2's hospital ER form dated 01/28/25 revealed the resident was seen for and diagnosed with recurrent seizures.

Review of Resident #2's physician's order dated 01/28/25 revealed an order to increase Keppra to 500mg 3 tablets (1,500mg) twice a day.

Review of Resident #2's hospital ER after visit summary (AVS) dated 02/01/25 revealed:
-The resident was seen for seizures.
-The resident's diagnoses included breakthrough seizure and hypomagnesemia (low magnesium levels).

Review of Resident #2's PCP visit note dated

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	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 7 02/06/25 revealed: -The resident was seen for monthly evaluation and ER follow-ups. -On 01/28/25, the resident was seen in the ER for recurrent seizures. -During this time, the resident's Keppra was increased to 1,500mg twice a day. -On 02/01/25, the resident was seen in the ER for hypomagnesemia and recurrent seizures. -Staff reported seizure-like activity during breakfast, however, the resident was back at baseline within less than 3 to 5 minutes. -There was an order to check the resident's Keppra level. Review of Resident #2's lab results, provider visit notes, and resident care notes revealed no documentation of any Keppra levels being checked for the resident. Review of Resident #2's electronic charting notes dated 02/09/25 at 8:54am revealed: -The resident had a seizure in the dining room and passed out. -He was taken to his room and back to bed; he locked his legs and slid out of chair and hit his head. -The resident was sent out to the hospital. Interview with the Office Manager on 02/13/25 at 1:03pm revealed: -She just contacted the lab manager and was told they received the order dated 02/06/25 for a Keppra level on 02/06/25. -The lab manager reported they came to the facility and attempted to draw the lab on Tuesday (02/11/25) but the resident was eating and they did not want to interrupt his meal. -The lab planned to go back to the facility today, but the lab was short of help.	D 273		

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	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

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D 273	Continued From page 8 -The lab was rescheduled for next week on Tuesday, 02/18/25. -She was not sure about the Keppra level ordered on 01/09/25. Interview with the Executive Director (ED) on 02/13/25 at 3:10pm revealed: -She faxed the order for the Keppra level dated 01/09/25 to the lab manager on 01/09/25. -The lab manager reported she did not receive the order dated 01/09/25 so the Keppra level was not checked. -She was responsible for checking lab order sheets when they received the results. -There was no system in place to make sure the fax was received by the lab. Telephone interview with the lab manager on 02/13/25 at 3:55pm revealed: -She had no record of receiving an order dated 01/09/25 for a Keppra level for Resident #2. -She received the order dated 02/06/25 for a Keppra level either on 02/06/25 or 02/07/25. -The lab staff were in the facility on Tuesday, 02/11/25, but the resident did not want to leave the dining room for the lab draw. -The lab staff was supposed to go back to the facility today, 02/13/25, to draw the Keppra level but the lab staff did not come to work due to illness. -She rescheduled the lab draw for the Keppra level for 02/18/25. Telephone interview with an on-call provider at the facility's contracted PCP office on 02/13/25 at 3:44pm revealed: -Resident #2's PCP was not available for interview today. -She checked the resident's file and there were no Keppra lab results in the resident's record.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

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D 273	Continued From page 9 -It was important to check the resident's Keppra level as ordered because the levels could be too low or too high, especially since the dosage had changed recently. -If the Keppra level was too low, it could be causing the breakthrough seizures. -If the Keppra level was too high, it could cause Keppra toxicity which could cause sedation and respiratory depression. _____ The facility failed to ensure health care referral and follow-up for Resident #1 and Resident #2. The facility did not coordinate and follow-up with care for an open wound identified on 01/29/25 on Resident #2's lower back which became reddened with yellow drainage, yellow pus and a foul, pungent odor on 02/13/25, requiring an order for wound culture, home health evaluation and antibiotic ointment. The facility failed to coordinate obtaining Keppra levels for Resident #2 who had a change in Keppra dosage and continued to have recurrent seizures. The failure of the facility to provide health care referrals and follow-up was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/13/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 30, 2025.	D 273		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service	D 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

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D 287	Continued From page 10 (b) Food Preparation and Service in Adult Care Homes: (2) Hot foods shall be served hot and cold foods shall be served cold as set forth in Rule 15A NCAC 18A .1620(a) for facilities with a licensed capacity of 7 to 12 residents and as set forth in Rule 15A NCAC 18A .1323 Food Protection in Activity Kitchens, Rehabilitation Kitchens, and Nourishment Stations for facilities with a licensed capacity of 13 or more residents, which are hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure hot foods were maintained hot until residents were ready to eat their meals for 1 of 5 sampled residents (#5). The findings are: Review of the weekly breakfast menu dated 02/12/25 revealed the meal was scrambled eggs, sausage patty, fresh fruit, whole grain toast, and 100% juices. Observation of Resident #5's breakfast meal on 02/12/25 at 7:43 am revealed: -He was served scrambled eggs, a sausage patty, strawberries, two whole grain toasts, milk, water, and coffee. -Resident #5 placed a small portion of his scrambled eggs on an empty plate and it was very cold to touch. -Resident #5 placed a small portion of his	D 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

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D 287	Continued From page 11	D 287		

sausage patty on an empty plate and it was very cold to touch.
-Resident #5 placed a small portion of his whole grain toast on an empty plate and it was very cold to touch.

Interview with Resident #5 on 02/12/25 at 11:50am revealed:
-His meals were always cold, and it was cold on Monday, 02/10/25.
-He did not ask the staff to warm up his plate or bring him a warm plate when it was cold.

Interview with the cook on 02/13/25 at 11:00am revealed:
-She was not aware that Resident #5's food was cold.
-Resident #5 had not complained to her that his food was cold.

Interview with the dietary kitchen aide on 02/13/25 at 11:05am revealed she was responsible to bring Resident #5 his meal to his table and he never complained to her about cold food.

Interview with the facility's on call primary care provider (PCP) on 02/13/25 at 3:20 revealed:
-She was not aware that Resident #5 food was cold during breakfast.
-She expected the staff to provide warm food to make it easier for him to digest.

Interview with the Executive Director (ED) on 02/13/25 at 11:15am revealed:
-She was not aware that Resident #5's food was cold during breakfast.
-Resident #5 had never told her that his food was cold.
-Staff was responsible for assisting all residents

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	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 287	Continued From page 12 including any issues with the plated meal.	D 287		
D 307	10A NCAC 13F .0904(e)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (e) Therapeutic Diets in Adult Care Homes: (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram, or consistency, such as for calorie-controlled ADA diets, low sodium diets, or thickened liquids, unless there are written orders that include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a licensed dietitian/nutritionist. For the purpose of this Rule "therapeutic diet" is a diet ordered by a physician, physician assistant, nurse practitioner, or a licensed dietician/nutritionist as delegated by the physician that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to obtain clarification for a written therapeutic diet order for 1 of 5 sampled resident (#5). The findings are: Review of Resident #5's current FL2 dated	D 307		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

(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 307	Continued From page 13	D 307		

09/20/24 revealed:
-Diagnoses included gastroesophageal reflux disease and chronic pain.
-There was an order for a mechanical soft (MS) diet.

Review of Resident #5's diet order dated 09/20/24 revealed no added salt (NAS), and MS diet.

Observation of the facility's diet extension dated 02/12/25 on 02/12/25 at 02/12/25 at 11:50am revealed instructions for a MS chopped and a MS ground diet.

Observation of Resident #5's breakfast meal on 02/12/25 at 7:43am revealed:
-He was served scrambled eggs, a sausage patty, strawberries, two whole grain toasts, milk, water, and coffee.
-The sausage patty that was not MS chopped or ground.

Interview with Resident #5 on 02/12/25 at 11:50am revealed:
-He was not aware that he was on a MS diet.
-He had a stroke in 2024, could not recall the month, and was unable to use his left hand and needed assistance cutting his food.
-He had asked staff on some days in the dining room to cut the food up for him and he was told to wait, and sometimes they would not come back, he could not recall the last time he had asked.

Interview with the cook on 02/13/25 at 11:00am revealed:
-She thought Resident #5 diet order was a regular diet.
-He had been on a MS diet in the past but refused chopped meat and would not eat the MS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043006	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

(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 307	Continued From page 14 diet, so she gave him a regular diet without a diet order. -She told the Executive Director (ED) that he refused to eat MS, and she let the mediation aide (MA) know but could not recall when she told them. Interview with the facility's on call primary care provider (PCP) on 02/13/25 at 3:20 revealed: -She was not aware that Resident #5 was on a MS diet, and she believed MS meant to provide soft foods. -She was not aware that he refused the MS diet. -She expected the facility's staff to notify the PCP of any refusal of the diet order. Interview with the ED on 02/13/25 at 11:15am revealed: -Resident #5's diet order showed a MS diet, but did not specify and she or the cook would give him chopped meats. -She did not clarify the diet order with the PCP. -She was aware that Resident #5 would refuse the MS meals, and she instructed dietary staff to provide him with a regular plate with no diet order. -She notified the PCP of his refusal of MS diet, she could not recall when, but the order was never changed. -She was responsible for getting clarification of diet orders.	D 307		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 451	Continued From page 15	D 451		

accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to complete an incident/accident report and notify the county department of social services (DSS) for 1 of 3 sampled residents (#2) who required emergency medical and hospital evaluations for a fall.

The findings are:

Review of Resident #2's current FL-2 dated 01/16/25 revealed diagnoses included epilepsy (seizure disorder), hypertension, history of thrombosis, benign prostatic hypertrophy, insomnia, gastroesophageal reflux disease, and schizophrenia.

Review of Resident #2's electronic charting note dated 02/09/25 at 8:54am revealed:
-The resident had a seizure in the dining room and passed out.
-He was taken to his room and back to bed; he locked his legs and slid out of chair and hit his head.
-The resident was sent out to the hospital.

Review of Resident #2's incident/accident reports for February 2025 revealed there was no incident/accident report for the resident's fall on 02/09/25.

Interview with a medication aide (MA) on

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D 451	Continued From page 16 02/13/25 at 12:53pm revealed: -She was working on 02/09/25 when Resident #2 had a seizure in the dining room. -She transferred the resident from the dining room chair to a wheelchair and transported the resident to his room. -While assisting the resident with transferring from the wheelchair to the bed, the resident locked his legs and slid out of the wheelchair. -The resident hit his head on the floor, so she called emergency medical services (EMS) and the resident was taken to the hospital. -The MA on duty at the time of an incident was responsible for completing an incident/accident report and giving the report to the Executive Director (ED). -She could not remember if she completed an incident/accident report for Resident #2's fall on 02/09/25. Interview with the ED on 02/13/25 at 6:35pm revealed: -The MAs were responsible for completing an incident/accident report at the time of an incident. -The MAs were supposed to put the completed report in her file and contact her to let her know about the incident. -She was responsible for sending the incident/accident report to the local county department of social services (DSS). -The MA forgot to do an incident/accident report for Resident #2's incident on 02/09/25. -She did not recall if the MA contacted her about Resident #2's incident on 02/09/25. -Since no report was done, the county DSS was not notified of the incident on 02/09/25.	D 451		