STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092210	A. BUILDING: _____ B. WING _____	R 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTONWOOD LAKE BOONE	3560 HORTON STREET RALEIGH, NC 27607

(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, follow-up, and state involved complaint investigation from 05/06/25 to 05/08/25.	D 000	During survey, facility immediately placed all hygiene products and personal care supplies in rubbermaid totes, and all totes were placed in a locked closet in Memory Care.	Completed on 6/12/2025, monitoring will remain ongoing.
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an environment free of hazards including personal care items and a hair dryer in residents' rooms that were accessible to residents on the Special Care Unit (SCU) and a clean environment related to a resident's bathroom (#2). The findings are: 1. Review of the facility's census report on 05/06/25 revealed there were 19 residents living in the Special Care Unit (SCU) of the facility. Observation of room 3016 on the SCU on	D 079	Upon exit on 5/8/2025, facility ordered electronic RFID cabinet locks, to make vanity cabinets secured storage for hygiene products. RFID locks were installed successfully in all apartments in SCU on 6/17/2025 and all hygiene products were placed back into resident apartments,and are only accessible via key fob. Memory Care Wellness Coordinator will monitor locks weekly for function, as well as complete routine inspections to identify any products that need to be secured in resident bathrooms. ED and ESM will monitor monthly and retain log in ED office.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Eric Davis | TITLE: Sr. Executive Director | (X6) DATE: 6/17/2025

Reviewed and Acknowledged
O. Magdad 10/8/25

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D 079	Continued From page 1 05/06/25 at 9:25am revealed there were personal hygiene items; baby lotion (if swallowed contact poison control) mouth wash (do not swallow), antibacterial soap (eye irritation and harmful if swallowed get immediate medical attention), and dish detergent (potential for eye irritation) in the bathroom. Observation of room 3011 on the SCU on 05/06/25 at 9:30am revealed there were personal care products: deodorant (can be dangerous if swallowed, call the poison control center), body wash (mild gastrointestinal irritation with nausea, vomiting, and diarrhea), 2 in 1 shampoo and conditioner (mild gastrointestinal irritation with nausea, vomiting, and diarrhea) and an air freshener in the bathroom. Observation of room 3007 on the SCU on 05/06/25 at 9:32am revealed there were personal care products in the bathroom; body wash (mild gastrointestinal irritation with nausea, vomiting, and diarrhea), hand lotion (may cause eye irritation mild gastrointestinal irritation with nausea, vomiting, and diarrhea). Observation of room 3006 on the SCU on 05/06/25 at 9:33am revealed there were personal care products in the bathroom; shampoo (may cause eye irritation and gastrointestinal effects if swallowed), and body wash (may cause eye irritation). Observation of room 3001 on the SCU on 05/06/25 at 9:34am revealed there were personal care products in the bathroom and bedroom: volumes mousse (may cause eye irritation, irritation of the mouth and throat and nausea) and hand lotion (may cause eye irritation mild gastrointestinal irritation with nausea, vomiting,	D 079		

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D 079	Continued From page 2 and diarrhea). Observation of room 3002 on the SCU on 05/07/25 at 3:20pm revealed there were personal care products in the bathroom: body wash (mild gastrointestinal irritation with nausea, vomiting, and diarrhea), hand lotion (may cause eye irritation mild gastrointestinal irritation with nausea, vomiting, and diarrhea), deodorant (can be dangerous if swallowed, call the poison control center), and included a hair dryer that was plugged in (fatal shock if dropped or pulled into water unplug when not in use). Observation of room 3006 on the SCU on 05/07/25 at 3:19pm revealed there were personal care products in the bathroom; hand lotion (may cause eye irritation mild gastrointestinal irritation with nausea, vomiting, and diarrhea), deodorant (can be dangerous if swallowed, call the poison control center), antibacterial soap (eye irritation and harmful if swallowed get immediate medical attention). Interview with a medication aide (MA) on 05/07/25 at 10:50am revealed: -The resident's personal care products were supposed to be locked up in a bin and removed from their rooms. -The resident's personal care products were kept in the resident's rooms. -She did not know of a resident eating or drinking any personal care products. Interview with the interim Special Care Coordinator (SCC) on 05/07/25 at 10:55am revealed: -She was the compliance nurse that had been working as the interim SCC until an SCC could be hired.	D 079		

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D 079	Continued From page 3 -All personal care products in the SCU should be under lock and key for the residents safety. Interview with the Executive Director (ED) on 05/07/25 at 11:25am revealed: -Cleaning supplies were not allowed to be kept out in resident's rooms in the SCU. -He did not know that personal care products had to be locked up in the SCU. -Clinical staff were responsible for the removal of personal care products from the residents' rooms in SCU. -He was ultimately responsible for the safety of the SCU residents. 2. Review of Resident #2's current FL-2 dated 11/12/24 revealed: -Diagnoses including coronary artery disease, Parkinson's disease, hypertension, and type 2 diabetes. -Resident #2 was semi-ambulatory. Observation of Resident #2's bathroom on 05/06/25 at 9:45am revealed feces on the bathroom floor in front of the toilet and on the walls inside of the toilet bowl. Second observation of Resident #2's bathroom on 05/06/25 at 1:35pm revealed feces on the bathroom floor in front of the toilet and on the walls inside of the toilet bowl. Third observation of Resident #2's bathroom on 05/07/25 at 7:34am revealed feces on the bathroom floor in front of the toilet and on the walls inside of the toilet bowl. Review of housekeeping schedule revealed Resident #2's room was scheduled to be cleaned on Mondays after lunch.	D 079	Upon discovery of feces in the bathroom, housekeeping was called to address and deep clean the bathroom. Waltonwood care staff will perform checks of resident #2's bathroom approximately every two hours during the day and evening to ensure cleanliness of resident apartment and bathroom. Waltonwood Medication staff will visually inspect resident #2's apartment and bathroom to confirm cleanliness. Waltonwood housekeeping will check apartment daily to clean bathroom of resident #2.	Completed on 5/8/2025, and monitoring will remain ongoing.

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D 079	Continued From page 4 Interview with Resident #2's family member on 05/06/25 at 9:35am revealed: -She shared a room with Resident #2. -His bathroom often had feces in the toilet bowl. -Staff did not clean his bathroom regularly. -He often had to use the toilet with feces covering the toilet bowl. Interview with Resident #2 on 05/06/25 at 9:50am revealed the facility did not clean his bathroom enough. Telephone interview with family member on 05/06/25 at 1:39pm revealed: -The resident's apartment often smelled of urine. -Staff did not clean his room and bathroom properly. Telephone interview with a personal care aide (PCA) on 05/07/25 at 9:00am revealed: -Resident #2 often had feces in his toilet. -PCAs were supposed to clean up feces, urine, and blood when they saw it. -Housekeeping was supposed to deep clean and disinfect area. Interview with a medication aide (MA) on 05/07/25 at 9:45am revealed PCAs were responsible for cleaning any bodily fluid they saw immediately, then housekeeping was supposed to deep clean. Interview with a housekeeper on 05/07/25 at 11:00am revealed: -Housekeeping was scheduled to clean resident rooms once weekly. -PCAs were responsible for cleaning Resident #2's bathroom regularly. -Housekeeping was responsible for deep	D 079	RCM, Wellness Coordinators and Executive Director will continue to monitor and oversee the state of Resident #2's bathroom for cleanliness. Waltonwood care staff was reeducated on 6/10/2025 on the process for immediate clean up of feces or other bodily fluids, as well as the process for placing a work order with maintenance for a deep clean of the affected area.	

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D 079	Continued From page 5 cleaning and disinfecting bathrooms weekly. -Resident #2's bathroom should have been cleaned. -She believed his bathroom had not been cleaned because the facility was short staffed. Interview with the Resident Care Coordinator (RCC) on 10/11/23 at 3:32pm revealed: -PCAs were responsible to put a workorder in with housekeeping when there was a bathroom that needed to be cleaned. -She expected housekeeping to keep resident rooms and bathrooms clean. -Resident #2's bathroom should have been cleaned when staff first noticed the feces. Interview with the Administrator on 10/12/23 at 3:42pm revealed: -PCAs should have paged housekeeping to clean Resident #2's bathroom when they noticed the feces on the floor and in the toilet. -Resident #2 would have been assisted to the toilet multiple times in the two days the bathroom was dirty. -PCAs should have cleaned up what they could and put a work order in for housekeeping to clean thoroughly. -PCAs were responsible for informing housekeeping of rooms and bathrooms that needed to be cleaned. -He expected staff to clean up any accidents in the facility immediately.	D 079		
D 195	10A NCAC 13F .0608 (c-f) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents	D 195		

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D 195	Continued From page 6 (c) The aide shall provide personal care services and supervision needed by the residents. (d) Aides shall not provide housekeeping duties except: (1) Between the hours of 7:00 a.m. to 9:00 p.m.: (A) to prevent an accident or injury; (B) when occasionally attending to an individual resident housekeeping need; and (C) when the number of aides on duty exceeds the minimum required by Paragraph (a) of this Rule. (2) Between the hours of 9:00 p.m. to 7:00 a.m., as long as the housekeeping duties do not: (A) hinder the aide's care of residents or immediate response to resident calls; (B) do not disrupt the residents' normal lifestyles and sleeping patterns; and (C) do not take the aide out of view of where the residents are as the aide shall be prepared to care for the residents since that remains his or her primary duty. (e) Aides shall not be assigned food service duties except when providing assistance to individual residents who need help with eating and carrying plates, trays, or beverages to residents. (f) In addition to the staffing required for management and aide duties, there shall be additional staff to perform housekeeping and food service duties. Note: The following chart illustrates the required aide, supervisory and management staffing requirements for each eight-hour shift in facilities with a census of 21 or more residents according to Rules .0602, .0603, .0604, .0608, and .0609 of this Section.	D 195	On 4/2/2025, community immediately implemented agency staffing to support any vacancies ,and not only meet, but exceed required regulations for staffing and resident need. Waltonwood Lake Boone entered into agreement with two staffing agencies to ensure adequate staffing of the Assisted Living and Special Care Unit whenever needed to fill vacancies. This support will remain in place ongoing as our staffing needs fluctuate. Executive Director and Resident Care Manager (RN), will have consistent oversight of the resident care schedule. Staffing schedules will be available 2 weeks in advance, and Resident Care Manager, Wellness Coordinators, and Executive Director will work to fill vacancies prior to day of, with the exception of call outs. In the event of a call off, a capable staff person will be on call 24 hours per day to ensure coverage of shifts. If coverage of Waltonwood associates is not possible, we will cover the shift with outside agency staffing. In the event that outside agency support does not have the ability to staff our shifts, our Resident Care Manager or Wellness Coordinators will work on the floor to meet staffing requirements.	4/2/2025, and oversight remains ongoing.

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D 195	Continued From page 7 Bed Count Position Type First Shift Second Shift Third Shift 21 - 30 Aide 16 16 8 Supervisor Not Required Not Required Not Required Administrator In the building, or within 500 feet and immediately available. 31-40 Aide 16 16 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 41-50 Aide 20 20 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 51-60 Aide 24 24 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 61-70 Aide 28 28 24 Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator On call 71-80 Aide 32 32 24 Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator On call 81-90 Aide 36 36 24 Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 91-100 Aide 40 40 32 Supervisor 8 8 8** Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.	D 195	Resident Care Manager, Wellness Coordinators, and Executive Director will monitor the census fluctuations in the facility to add additional staffing when needed based on regulatory requirements and resident need. This will take place at our daily line up meeting. Executive Director and Resident Care Manager (RN), will review pendant reports daily to address any prolonged response times. Community has set up a daily report to be emailed to Resident Care Manager for any pendants exceeding 10 minutes. Any prolonged response times will be addressed the next business day. Resident Care Manager performed staff education on 5/9/2025 on the process and procedure for pendant response, as well as clearing active pendants. Waltonwood concierge team will call pendants over radio by room number to ensure that residents needs are addressed in a timely manner. Waltonwood Regional Director of Resident Care will review and report pendant response times to community every Friday. Resident Care Manager will ensure that all staff has adequate tools to clear pendants once activated.	

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101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
121-130 Aide 52 52 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
151-160 Aide 64 64 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
161-170 Aide 68 68 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
171-180 Aide 72 72 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
181-190 Aide 76 76 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
191-200 Aide 80 80 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40

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hours. When not in facility, on call.
201-210 Aide 84 84 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
211-220 Aide 88 88 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
221-230 Aide 92 92 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
231-240 Aide 96 96 64
Supervisor 24 24 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure adequate staff was available to provide personal care services needed by residents.

The findings are:

Review of the facility census sheet revealed the census at the time of the survey was 41 in assisted living.

5 out of 5 sampled residents needed help with activities of daily living (ADLs).

Review of call pendent for history for 2 of 5

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D 195	Continued From page 10 sampled residents (#1 and #2) from 04/01/25 through 05/06/25 revealed: -There were 15 documented response times that were 20 to 30 minutes. -There were 30 documented response times that were 30 minutes to an hour. -There were 10 documented response times that were over an hour. -There were 4 documented response times that were over 2 hours. Interview with a resident on 05/06/25 at 9:35am revealed: -The facility was often short staffed. -Her roommate needed assistance with going to the bathroom. -Staff had to transfer him from his wheelchair to the toilet. -Staff would assist him onto the toilet and leave. -Her roommate had wait for up to two hours sitting on the toilet for assistance. -She would press his call pendant for assistance, the average wait time was an hour. -She often had to go and find staff to assist with personal care. -She complained to the Administrator about this several times. Interview with a second resident on 05/06/25 at 9:50am revealed: -The facility did not have enough staff to provide personal care properly. -He had to wait on the toilet extended periods of time. -Morning incontinence care was often completed late. Interview with a third resident on 05/07/25 at 10:30am revealed: -There were times when there was only one	D 195		

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medication aide for all three floors.
-The facility often did not have enough staff to care for resident needs.
-Many residents complained that when they pressed their call pendants for assistance, staff never came.
-Residents would have to sit in the dining room and wait thirty minutes to an hour to be served.
-Residents often complained about meals being served late when they ate in their rooms.

Telephone interview with a residents family member on 05/06/25 at 1:39pm revealed:
-The facility did not have enough staff to properly care for residents.
-Her family member needed help with going to the toilet.
-The facility had a lack of response to residents pressing their call pendants for assistance.
-Her family member was left sitting on the toilet for up to an hour and a half waiting for staff assistance.

Telephone interview with a personal care aide (PCA) on 05/07/25 at 9:00am revealed:
-The facility did not have adequate staffing.
-She was often the only PCA providing personal care to 22-23 residents (the first floor).
-She was not always able to assist residents to the bathroom or give showers due to staffing shortages.
-Residents would have to "lay in soiled diapers" for up to an hour before she could assist them with morning care.
-Often she was not able to answer resident call pendants for up to an hour due to short staffing.
-Resident call pendants were supposed to be answered in 7 minutes.

Interview with a medication aide (MA) on

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D 195	Continued From page 12 05/07/25 at 9:45am revealed: -The facility had been understaffed up until a month ago. -Staff would not be able to answer resident call pendants for extended periods of time. -Residents personal care was not always provided, she needed more assistance to take care of residents and their medications. Interview with a second MA on 05/07/25 at 10:15am revealed: -The facility did not have adequate staff. -Residents would have to wait an average of 30 minutes for assistance when they pressed their call pendants. -She often had to act as an MA and PCA due to staffing shortages. Interview with the Resident Care Coordinator (RCC) on 05/08/23 at 11:15am revealed she expected staff to respond to resident call pendants in under 10 minutes. Interview with the Administrator on 05/08/25 at 10:20am revealed: -The facility had staffing shortages in the special care unit up until a month ago. -The facility began using agency staff to work in the facility. -He expected call pendants to be responded to in under 9 minutes. -PCAs and MAs were responsible for responding to resident pendent calls. -The reason for the longer documented call log responses was the agency staff did not have the ability to reset resident call pendants. -He expected staff to complete personal care in a timely manner.	D 195		

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D 269	Continued From page 13	D 269	Waltonwood staff was educated on 5/9/2025, 6/9/2025, and 6/10/2025 regarding the importance of proper continence care, understanding the care plan in relation to resident needs. Staff was also educated on remaining with residents that may be at risk of skin breakdown while they are on the toilet to minimize pressure to the sacral area. Resident #2 is currently receiving home health services for wound care. Staff have been instructed to report any refusals of care or refusals to offload pressure on his sacrum. Resident Care Manager will meet with Home Health organization bi-weekly to review wound status. At this time, any adjustments to care will be made based on refusals and wound status. Home Health has been instructed to report any immediate changes with wound to Resident Care Manager or Executive Director. Resident Care Manager or Wellness Coordinator will review physician progress notes to ensure all orders are being carried out in a timely manner and implemented by staff.	Completed on 5/9/2025 and oversight will remain ongoing.
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 interviews and record reviews, the facility failed to provide personal care according to the resident care plan for 1 of 5 sampled residents (#2) who needed assistance with toileting tasks and personal hygiene. The findings are: Review of Resident #2's current FL-2 dated 11/12/24 revealed: -Diagnoses including coronary artery disease, Parkinson's disease, hypertension, and type 2 diabetes. -Resident #2 was semi-ambulatory. -No information on orientation. Review of Resident #2"s Resident Register revealed he was admitted to the facility on 10/07/22. Review of Resident #2's current service plan dated 01/29/25 revealed: -He required moderate assistance with mobility/ambulation. -He required moderate assistance with transportation. -He required moderate assistance with grooming and personal hygiene.	D 269		

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D 269	Continued From page 14 -He required moderate assistance with toileting. Review of a Primary Care Provider (PCP) visit note dated 01/30/25 revealed: -Resident #2 had a stage one pressure ulcer on his bottom. (A stage 1 pressure ulcer is characterized by a non-blanchable redness of intact skin, indicating early tissue damage due to pressure.) -There was a treatment plan to start home health for wound care. -Nystatin 100,000 units/gram powder ordered, apply to groin and bottom twice per day. Review of a PCP visit note dated 04/08/25 revealed: -Resident #2 had a stage 2 pressure ulcer on bottom. (A stage 2 pressure ulcer is defined as partial-thickness loss of skin with exposed dermis.) -There was a treatment plan to start home health for wound care. -Physical therapy and occupational therapy ordered to help with transfers to avoid further breakdown. Review of home health notes dated 04/29/25 revealed: -Home health services were initiated on 04/11/25. -Resident #2 had a stage 2 pressure ulcer on his right buttock. -Measurements were length was 4 centimeters (cm), width was 3 cm, and depth was 0.1cm, surface area was 12 square cm. Review of call pendent history from 04/01/25 through 05/06/25 for Resident #2 revealed: -There were 15 documented response times that were 20 to 30 minutes. -There were 26 documented response times that	D 269		

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D 269	Continued From page 15 were 30 minutes to an hour. -There were 7 documented response times that were over an hour. -There were 3 documented response times that were over 2 hours. Interview with Resident #2's roommate on 05/06/25 at 9:35am revealed: -She shared a room with Resident #2. -Resident #2 needed assistance with going to the bathroom. -Staff had to transfer Resident #2 from his wheelchair to the toilet. -Resident #2 had to wait for up to two hours sitting on the toilet for assistance. -Resident #2 would press his call pendant for assistance, the average wait time was an hour. -She often had to go and find staff to assist Resident #2 with personal care. Interview with Resident #2 on 05/06/25 at 9:50am revealed: -He needed incontinence care each morning. -He had to wait on the toilet extended periods of time. -His morning care was often completed late. Telephone interview with a family member on 05/06/25 at 1:39pm revealed: -When she visited the facility the apartment often smelled of urine. -Resident #2 needed help with going to the toilet. -The facility had a lack of response to residents pressing their call pendants for assistance. -Resident #2 was left sitting on the toilet for up to an hour and a half waiting for staff assistance. Telephone interview with a personal care aide (PCA) on 05/07/25 at 9:00am revealed: -She was often the only PCA providing personal	D 269		

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care to 22-23 residents on the first floor.
-She could only assist one resident at a time.
-Often she was not able to answer resident call pendants for up to an hour.
-Residents would have to "lay in soiled briefs" for up to an hour before she could assist them with morning care.

Interview with a medication aide (MA) on 05/07/25 at 9:45am revealed:
-The facility had been understaffed.
-Residents personal care was not always provided, she needed more assistance to take care of all the residents and their medications.

Interview with a second MA on 05/07/25 at 10:15am revealed:
-Residents would have to wait an average of 30 minutes for assistance.
-She often had to act as an MA and PCA due to staffing shortages.

Telephone interview with a nurse from Resident #2's home health agency on 05/07/25 at 2:50pm revealed:
-Resident #2 was admitted to home health on 04/11/25.
-He was referred to home health for wound care for a pressure ulcer on his right buttocks.
-The resident sitting in urine and feces for long periods of time would have contributed to skin breakdown.
-The resident sitting on the toilet for long periods of time could have contributed to skin breakdown.
-Resident #2 should have been getting personal care promptly to help keep the area dry and clean.

Interview with the Administrator on 05/08/25 at 10:20am revealed:

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D 269	Continued From page 17 -He expected staff to complete personal care in a timely manner. -He expected staff to stay with Resident #2 during toilet assistance and transfer him immediately when he was ready. -He was concerned that lack of incontinence care could cause progression of Resident #2's skin breakdown. Attempted telephone interview with Resident #2's PCP on 05/07/25 at 2:00pm was unsuccessful.	D 269		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure mealtime service consisted of non-disposable place settings. The findings are: Observation in the Special Care Unit (SCU) on 05/06/25 between 9:16am and 9:30am revealed	D 286	Facility immediately implemented delivery meal service on china and is no longer using disposable dinnerware, with the exception of residents under isolation. This was implemented during ongoing survey. Additional china for delivery meals was ordered on 5/10/2025 to ensure adequate supply.	Completed on 5/8/2025 and remains ongoing.

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residents that were eating breakfast in their rooms were served using disposable covered containers, disposable cups, and disposable utensils including a fork, spoon, and knife. Second observation in the SCU on 05/07/25 between 9:00am and 9:30am revealed residents that were eating breakfast in their rooms were served using disposable covered containers, disposable cups, and disposable utensils including a fork, spoon, and knife.

Interview with a medication aide (MA)on 05/07/25 at 10:40am revealed:
-She had worked at the facility for over 4 years.
-Residents that ate in their rooms were served using disposable place settings.
-She knew that residents were supposed to have their meals served using regular place settings.

Interview with the interim Special Care Coordinator (SCC) on 05/07/25 at 10:55am revealed:
-She was the compliance nurse that had been working as the interim SCC until an SCC could be hired.
-She knew that the SCU residents that ate in their rooms were being served on disposable place settings.
-She was not well versed on dietary regulations.

Interview with the Dietary Supervisor on 05/07/25 at 11:05am revealed:
-The residents that ate in their rooms were served on disposable place settings.
-She did not know that disposable place settings were not to be used.

Interview with the facility Chief on 05/07/25 at 11:15am revealed:
-He had worked at the facility for less than one

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D 286	Continued From page 19 year. -He did not know that the facility was not supposed to serve residents who ate in their rooms on disposable plate settings. Interview with the Executive Director on 05/07/25 at 11:25am revealed: -He knew that the residents that ate their meals in their rooms were served on disposable place settings. -He did not know that the facility was not supposed to use disposable place settings when residents ate in their rooms.	D 286		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide meals in a timely manner for residents. The findings are:	D 297	Facility immediately addressed this issue on 5/8/2025 by delivering room service meals concurrently during breakfast service and concurrently during lunch and dinner, rather than waiting until after service. Facility has assigned a server to deliver meals to residents in their apartments for all 3 meals daily. CSM/Culinary Supervisor will monitor timliness of meal deliveries and address any delays as they occur.	Completed on 5/8/2025 and remains ongoing.

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D 297	Continued From page 20 Observation during the initial tour on 05/06/25 between 9:30am and 10:00am revealed: -Residents who were eating breakfast in their rooms had not received their meal. -There was a resident yelling "I'm hungry, I want my cereal but it may take a while before I get something to eat." Interview with a resident on 05/06/25 at 10:00am revealed: -She filled out menus for breakfast, lunch and dinner the day before and still had to fill them out again the next day. -Her meals were often late. -She did not know what the problem was with meals being late, but she knew there was a problem. Interview with a second resident on 05/08/25 at 10:30 am revealed: -The facility often served meals late. -Residents would have to sit in the dining room and wait thirty minutes to an hour to be served. -Residents often complained about meals being served late when they ate in their rooms. Interview with a personal care aide (PCA) on 05/06/25 at 9:38am revealed: -The PCAs went to each residents' room daily to check if the resident wanted to eat in their rooms or in the dining room for meals. -The PCAs would take the residents' menus to the kitchen. -The kitchen normally had meals ready for breakfast between 9:00am and 9:30am. -She did not know why the breakfast meal was not ready for delivery or pickup. Interview with a second PCA on 05/07/25 at 10:40am revealed:	D 297		

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D 297	Continued From page 21 -Meals were often delivered late to the residents' rooms. -There was no organization for meal deliveries to the residents' rooms. Interview with the dining services supervisor on 05/07/25 at 9:00am revealed: -The PCAs took the menus from the residents to the dining room. -The kitchen staff then filled the orders from the menus and placed them in a brown paper bag on a table in the dining room. -The PCAs delivered the meals to the residents if they stated delivery. -Some residents came to the dining room to pick up their meals. -The breakfast meal deliveries should be made to the residents' rooms by 9:00am. -The meals were delivered late on 05/06/25 during breakfast because she was short staffed.	D 297		