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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
	HAL019019	A. BUILDING: _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE HILLS OF PITTSBORO	P O BOX 1209 PITTSBORO, NC 27312

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D 000	Initial Comments The Adult Care Licensure Section completed an annual and follow up survey on May 20-21, 2025	D 000	① The deficiency was identified the first day of survey. The facility was notified of the deficiency during exit interviews, therefore it could not be immediately corrected by placing the TED hose on the resident legs. ② The facility will conduct training with pertinent staff on the importance of TED hose and their application. This training will be conducted by our Consultant Nurse by July 18. ③ The Health Care Director Reviewed TED hose orders with the ordering physician/provider to ensure appropriateness of the orders. Several orders were adjusted. ④ The Resident Care Coordinator and Health Care Director will do Random monitoring - at least 2x/month, to check for compliance with TED hose and will document the checks.	
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure physician orders for Thrombo-embolus deterrent (TED) hose were implemented for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's current FL-2 dated 02/28/25 revealed diagnoses included bilateral osteoarthritis in the knees, neuropathy, and dizziness. Review of Resident #3's signed physician's order dated 03/25/25 revealed an order for TED hose for bilateral edema apply and remove daily; 12 hours on and 12 hours off. Review of Resident #3's signed physician's order date 04/15/25 revealed an order for staff to assist resident daily with application and removal of her compression socks.	D 276		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

MO Lobb, Executive Director 6/27/2025

STATE FORM 6899 PTV711 If continuation sheet 1 of 20

⑤ This Tag Will be Completed by July 18, 2025.

Reviewed and acknowledged 07.03.25 kc

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D 276	Continued From page 1 Review of Resident #3's electronic medication administration record (eMAR) for March 2025 revealed there was no entry for the daily application and removal of Resident #3's TED hose. Review of Resident #3's eMAR for April 2025 revealed: -There was an entry for compression stockings apply compression socks daily in the morning and remove at bedtime with a scheduled application at 8:00am and removal at 8:00pm; staff to assist with application. -There was one refusal documented on 04/23/25. Review of Resident #3's eMAR for May 2025 from 05/01/25 to 05/20/25 revealed: -Resident #3's compression stockings were documented as applied and removed daily from 04/01/25 to 04/19/25. -There was documentation Resident #3's compression stockings were applied on 04/20/25 at 8:00am. Observations of Resident #3 at on 04/20/25 at various times from 9:45am to 4:10pm revealed: -At 9:45am, Resident #3 was seated in a recliner in her room with her feet on the floor; she did not have her TED hose on. -Her feet, ankles and lower legs were swollen and there were red blotches on her shins. -At 11:55am, she was seated in a recliner in her room with her feet on the floor; she did not have her compression stockings on. -Resident #3's feet, ankles and lower legs were swollen, and red blotches covered her shins. -Resident #3's compression stockings were laying on top of a laundry basket. -Her compression stockings were thick, white and closed-toed.	D 276		

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D 276	Continued From page 2 -At 4:10pm, Resident #3 was in a wheelchair near the nurses' station with her feet on the floor. -Resident #3 did not have on her compression stockings; her feet, ankles, and lower legs were noticeably swollen and red. Interviews with Resident #3 on 04/20/25 at 11:55am and 4:10pm revealed: -The medication aides (MAs) applied her compression stockings in the mornings and removed them for her at night. -The MA did not apply her compression stocking this morning, 04/20/25 because the MA rubbed a cream to her legs. -She asked the MA to come back later after the cream soaked in and apply the compression stockings. -At 11:55am, the MA had not come back to apply her compression stockings. -At 4:10pm, the MA had not come back to apply her compression stockings. -She could not tell if her legs were swollen. -She never took her compression stocking off herself. -She wore them all day when they were applied. -Some MAs did not apply the compression stockings; it depended on who was working. Telephone interview with Resident #3's primary care provider (PCP) on 04/21/25 at 10:01am revealed: -Resident #3 had some swelling in her lower legs that was controlled with a medication. -Resident #3 was ordered compression stockings as a conservative intervention for her swelling; the constant compression would help reduce the swelling. -He expected his order to be followed by the MAs and for Resident #3 to wear the compression stockings every day.	D 276		

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D 276	Continued From page 3 Interview with a MA on 05/21/25 at 11:10am revealed: -Resident #3 complained about her compression stockings as they were applied but she always let her apply them. -Resident #3 complained her legs were sore from wearing the compression stockings. -Resident #3 would call the MAs around 7:00pm and ask them to remove the compression stockings. -Resident #3 had compression stockings on yesterday, 05/20/25. -She applied Resident #3's cream to her legs around 9:00am yesterday. -Resident #3 wanted the compression stockings removed after the cream was applied to her legs so the cream could dry. -It took about 20 minutes for the cream to dry. -She went back and reapplied Resident #3's compression stockings; she did not recall what time she reapplied the compression stockings. -She could not recall if she had seen Resident #3 with her compression stockings on after she reapplied them. Interview with a second MA on 05/21/25 at 11:30am revealed: -Resident #3 had compression stocking that were applied every morning. -Resident #3 did not want her compression stockings applied until after the medicated cream that was applied to her legs soaked into her skin. -She would apply the medicated cream to Resident #3's legs and then go back around thirty minutes later and apply her compression stockings. -Resident #3 did not refuse to wear her compression stockings; if she wanted them removed, she called the MAs to remove them.	D 276		

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D 276	Continued From page 4 -Resident #3 did not remove them herself. Interview with the Health and Wellness Director (HWD) on 05/21/25 at 2:35pm revealed: -The staff was responsible for applying and removing compression stockings. -Resident #3 was admitted to the facility with compression stockings. -Resident #3 would refuse to let staff apply her compression stockings. -If a resident refused to let staff apply their compression stocking the staff would wait for about a half an hour and attempt again at applying them. -Staff were required to document refusals on the eMAR. -It the resident did not have compression stockings on when staff went to remove them it should be documented on the eMAR. -The MA should have attempted to apply or reapply Resident #3's compression stockings. Interview with the Administrator on 05/21/25 at 3:25pm revealed: -The staff applied and removed residents' compression stockings. -Refusals were documented on the eMAR. -When a resident refused to have their compression stockings applied the staff should try again after a bit of time. -The MA should let the HWD know the resident refused their compression stocking or the resident was removing them. -The MA should not document on the eMAR until after she applied the compression stockings. -The compression stockings were ordered for a reason so he expected the MA to follow the PCP's order.	D 276		

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D 311	Continued From page 5	D 311		
D 311	10A NCAC 13F .0904(f)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (1) The facility shall provide staff for individual feeding assistance in accordance to residents' needs. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure staff provided individual feeding assistance for 9 of 9 sampled residents (#6, #7, #8, #9, #10, #11, #12, #13, #14) in accordance with the resident's needs. The findings are: 1. Review of Resident #6's current FL-2 dated 05/05/25 revealed: -Diagnoses included weakness, osteoarthritis, hypertension and hyperthyroidism. -Resident #6 required assistance with bathing, dressing and feeding. -He had an order for a regular diet. Review of Resident #6's current care plan dated 02/11/25 revealed he required supervision from staff with eating. Observations of the lunch meal in the Assisted Living (AL) on 04/20/25 from 12:00pm to 12:31pm revealed: -Resident #6 was seated in his wheelchair at the	D 311		

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D 311	Continued From page 6 end of a semi-circular table with three other residents. -There was a medication aide (MA) seated on the inside of the semi-circular table. -Resident #6 was served ground meatballs with gravy, rice, green beans, a roll, diced pears, water, milk and iced tea. -The MA cut food and cued two of the residents seated at the table with Resident #6 to eat. -At 12:15pm, the MA began to feed Resident #6. -At 12:20pm, the MA fed a few bites of food to Resident #6 then moved her chair to another resident seated at the opposite end of the semi-circular table. -The MA cut another resident's food and then began to feed that resident. -At 12:21pm, she moved her chair back to Resident #6 and fed him multiple bites of food. -At 12:24pm, she moved her chair back to the other resident and began to feed that resident again. -At 12:25pm, she moved her chair back to Resident #6 and fed him and offered him beverages. -At 12:28pm, she moved her chair back to Resident #6 and fed him. -At 12:31pm, Resident #6 left the dining room. -Resident #6 ate 100% of his meatballs and rolls, half of his pears, less than 10% of his green beans, half of his iced tea, none of his milk or water. Telephone interview with Resident #6's primary care provider (PCP) on 04/21/25 at 10:35am revealed: -He was not aware Resident #6 required feeding assistance at meals. -Resident #6 had multiple hospital visits recently and was beginning to decline.	D 311	① An assessment was Conducted by the Health Care Director, Resident Care Coordinator, and the Dietary Manager to generate a Complete List of who needs fed or cued/prompted. ② Seating in the dining room was evaluated and changes were made based on who needs fed. ③ Each Resident needing assistance with feeding will be fed individually by staff. ④ If there are more feeders than available staff, we will modify meal times if necessary so each resident is fed individually. ⑤ We will document modified meal times if necessary. ⑥ Training on new seating and feeding schedules was conducted by Health Care Director, Resident Care Coordinator, and Dietary Manager to all daytime staff on 6/20/25 and 6/23/25. ⑦ This arrangement will be Monitored continuously and changes will be made/adjusted as soon as identified. ⑧ This TAG was Completed on 6/23/25 with our new Seating plan and feeding Schedules.	

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D 311	Continued From page 7 Interview with a MA on 04/21/25 at 11:01am revealed: -Resident #6 could feed himself. -Resident #6 had to be monitored because he would eat too fast and put too much food in his mouth. Interview with a second MA on 05/21/25 at 11:30am revealed: -Resident #6 would take a few bites himself then he would sit and not eat anything. -Sometimes if you put the food on the spoon for Resident #6, he would begin to feed himself. -She would feed Resident #6 when he did not feed himself. Based on observations, interviews and record reviews Resident #6 was not interviewable. Refer to the telephone interview with the facility's primary care provider (PCP) on 04/21/25 at 10:35am. Refer to the interview with MA on 04/21/25 at 11:01am. Refer to the interview with a second MA on 05/21/25 at 11:30am. Refer to the interview with the Special Care Unit (SCU) Coordinator on 04/21/25 at 1:40pm Refer to the interview with the Health and Wellness Director (HWD) on 05/21/25 at 2:10pm. Refer to the interview with the Administrator on 05/21/25 at 3:15pm. 2. Review of Resident #7's current FL-2 dated 07/08/24 reveald diagnoses included	D 311		

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D 311	Continued From page 8 hypertension, late onset Alzheimer's disease, and macular degeneration. Review of Resident #7's physician's order dated 05/06/25 revealed there was an order for a regular diet. Review of Resident #7's current care plan dated 08/27/24 revealed she was independent with eating and required no assistance from staff. Interviews with a medication aide (MA) on 04/21/25 at 8:27am and 11:01am revealed: -Sometimes she would cut up some of Resident #7's food for her. -Resident #7 could feed herself. -Sometimes Resident #7 would not eat and would just sit. -Resident #7 needed coaxing to eat and drink. -Resident #7 could vary from day to day or meal to meal. -When Resident #7 did not feed herself, she would feed Resident #7. Interview with a second MA on 05/21/25 at 11:30am revealed: -Resident #7 needed to be fed at every meal. -Resident #7 would sit and not eat. -She would eat some food with her hands on her own. -Resident #7 would not pick up or take a spoon and eat on her own. -She had to feed Resident #7 and coax her while she was feeding her. Based on observations, interviews and record reviews Resident #7 was not interviewable. Refer to the telephone interview with the facility's primary care provider (PCP) on 04/21/25 at	D 311		

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D 311	Continued From page 9 10:35am. Refer to the interview with MA on 04/21/25 at 11:01am. Refer to the interview with a second MA on 05/21/25 at 11:30am. Refer to the interview with the Special Care Unit (SCU) Coordinator on 04/21/25 at 1:40pm Refer to the interview with the Health and Wellness Director (HWD) on 05/21/25 at 2:10pm. Refer to the interview with the Administrator on 05/21/25 at 3:15pm. 3. Review of Resident #8's current FL-2 dated 05/05/25 revealed: -Diagnoses included lower body edema, malnutrition and history of falls. -She had an order for a regular diet. Review of Resident #8's current care plan dated 11/04/24 revealed she required extensive assistance from staff with eating. Observation of Resident #8 during the breakfast meal in the Special Care Unit (SCU) on 05/21/25 at 8:00am revealed: -She was sitting in the dining room in her wheelchair at a half-moon table with three other residents. -Resident #8 was served oatmeal, pureed waffles and eggs. -There was a cup of juice, water and milk in front of her place setting. -There was a personal care aide (PCA) spoon feeding her the meal.	D 311		

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D 311	Continued From page 10 -The PCA fed three additional residents at the same time. -She ate 50% of the oatmeal, 100% of the eggs and 0% of the waffle. -The PCA offered her milk, water and juice. -She drank 10% of the water and 25% of the juice and 25% of the milk. Based on observations, interviews and record reviews Resident #8 was not interviewable. Refer to the telephone interview with the facility's primary care provider (PCP) on 04/21/25 at 10:35am. Refer to the interview with MA on 04/21/25 at 11:01am. Refer to the interview with a second MA on 05/21/25 at 11:30am. Refer to the interview with the Special Care Unit (SCU) Coordinator on 04/21/25 at 1:40pm Refer to the interview with the Health and Wellness Director (HWD) on 05/21/25 at 2:10pm. Refer to the interview with the Administrator on 05/21/25 at 3:15pm. 4. Review of Resident #9's current FL-2 dated 08/27/24 revealed: -Diagnoses included dementia, anxiety disorder and insomnia. -She had an order for a regular diet. Review of Resident #9's current care plan dated 09/10/24 revealed she required extensive assistance from staff with eating.	D 311		

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D 311	Continued From page 11 Observation of Resident #9 during the breakfast meal in the SCU on 05/21/25 at 8:00am revealed: -She was sitting in the dining room at a half-moon table with three other residents. -Resident #9 was served oatmeal, eggs, bacon, waffles and sliced apples. -There was a PCA spoon feeding her the meal. -The PCA fed three additional residents at the same time. -She ate 25% of the oatmeal, 100% of the eggs, 50% of the bacon, 0% of the waffle and 50% of the apples. -She drank 20% of the milk, and 20% of the water and 50% of the juice. Based on observations, interviews and record reviews Resident #9 was not interviewable. Refer to the telephone interview with the facility's primary care provider (PCP) on 04/21/25 at 10:35am. Refer to the interview with MA on 04/21/25 at 11:01am. Refer to the interview with a second MA on 05/21/25 at 11:30am. Refer to the interview with the Special Care Unit (SCU) Coordinator on 04/21/25 at 1:40pm Refer to the interview with the Health and Wellness Director (HWD) on 05/21/25 at 2:10pm. Refer to the interview with the Administrator on 05/21/25 at 3:15pm. 5. Review of Resident #10's current FL-2 dated 02/04/25 revealed: -Diagnoses included Alzheimer's disease,	D 311		

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D 311	Continued From page 12 influenza and B12 deficiency. -She had an order for a regular diet. Review of Resident #10's care plan dated 01/22/25 revealed she required extensive assistance with eating. Observation of Resident #10 during the breakfast meal in the SCU on 05/21/25 at 8:00am revealed: -She was sitting in the dining room at a half-moon table with three other residents. -Resident #10 was served oatmeal, eggs, bacon, waffles and sliced apples. -She was served juice, coffee and milk. -There was a PCA verbally prompting her to eat her meal. -The PCA fed three additional residents at the same time. -She ate 25% of the oatmeal, 0% of the eggs, 25% of the bacon, 50% of the waffle and 75% of the apples. -She drank 50% of the milk, and 10% of the water and 50% of the coffee. Based on observations, interviews and record reviews Resident #10 was not interviewable. Refer to the telephone interview with the facility's primary care provider (PCP) on 04/21/25 at 10:35am. Refer to the interview with MA on 04/21/25 at 11:01am. Refer to the interview with a second MA on 05/21/25 at 11:30am. Refer to the interview with the Special Care Unit (SCU) Coordinator on 04/21/25 at 1:40pm	D 311		

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	HAL019019	A. BUILDING: _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE HILLS OF PITTSBORO	P O BOX 1209 PITTSBORO, NC 27312

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D 311	Continued From page 13 Refer to the interview with the Health and Wellness Director (HWD) on 05/21/25 at 2:10pm. Refer to the interview with the Administrator on 05/21/25 at 3:15pm. 6. Review of Resident #11's current FL-2 dated 11/08/24 revealed: -Diagnoses included Alzheimer's type dementia, hearing loss, wondering, glaucoma, psoriatic arthritis, high blood pressure, atherosclerotic disease and obstructive sleep apnea syndrome. -He had an order for a regular diet with cut meats. Review of Resident #11's care plan dated 11/22/24 revealed he was totally dependent on staff for feeding assistance. Observation of Resident #11 during the breakfast meal in the SCU on 05/21/25 at 8:00am revealed: -Resident #11 was sitting in the dining room in his wheelchair at a half-moon table with three other residents. -Resident was served oatmeal, eggs, bacon, waffles and sliced apples. -There was a PCA feeding the resident. -The PCA fed three additional residents at the same time. -He ate 100% of the oatmeal, eggs, bacon, waffles and sliced apples. -He drank 100% of the milk, water, juice and coffee. Based on observations, interviews and record reviews Resident #11 was not interviewable. Refer to the telephone interview with the facility's primary care provider (PCP) on 04/21/25 at 10:35am.	D 311		

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D 311	Continued From page 14 Refer to the interview with MA on 04/21/25 at 11:01am. Refer to the interview with a second MA on 05/21/25 at 11:30am. Refer to the interview with the Special Care Unit (SCU) Coordinator on 04/21/25 at 1:40pm Refer to the interview with the Health and Wellness Director (HWD) on 05/21/25 at 2:10pm. Refer to the interview with the Administrator on 05/21/25 at 3:15pm. 7. Review of Resident #12's current FL-2 dated 05/05/25 revealed: -Diagnoses included Alzheimer's disease and hypercholesterolemia. -The was an order for a regular diet. Observation of Resident #12 during the breakfast meal in the SCU on 05/21/25 at 8:00am revealed: -She was sitting in the dining room at a half-moon table with three other residents. -Resident #12 was served oatmeal, eggs, bacon, waffles and sliced apples. -There was a cup of juice, coffee and milk in front of her place setting. -There was a PCA cutting up her food and feeding her meal to her. -The PCA fed three additional residents at the same time. -She ate 0% of the oatmeal, 50% of the eggs, 100% of the bacon, 0% of the waffle and 50% of the apples. -She drank 50% of the milk, 20% of the water and 100% of the juice. Based on observations, interviews and record	D 311		

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D 311	Continued From page 15 reviews Resident #12 was not interviewable. Refer to the telephone interview with the facility's primary care provider (PCP) on 04/21/25 at 10:35am. Refer to the interview with MA on 04/21/25 at 11:01am. Refer to the interview with a second MA on 05/21/25 at 11:30am. Refer to the interview with the Special Care Unit (SCU) Coordinator on 04/21/25 at 1:40pm Refer to the interview with the Health and Wellness Director (HWD) on 05/21/25 at 2:10pm. Refer to the interview with the Administrator on 05/21/25 at 3:15pm. 8. Review of Resident #13's current FL-2 dated 07/26/24 revealed: -She had a diagnosis of dementia. -She had an order for a regular diet. Review of Resident #13's care plan dated 07/09/24 revealed she was totally dependent on feeding assistance. Observation of Resident #13 during the breakfast meal in the SCU on 05/21/25 at 8:00am revealed: -She was sitting in the dining room at a half-moon table with three other residents. -Resident #13 was served oatmeal, eggs, bacon, waffles and sliced apples. -She was served juice, coffee and milk. -There was a PCA verbally prompting her to eat her meal. -The PCA fed three additional residents at the	D 311		

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D 311	Continued From page 16 same time. -She ate 0% of the oatmeal, 50% of the eggs, 100% of the bacon, 50% of the waffle and 100% of the apples. -She drank 25% of the milk, and 25% of the water and 10% of the juice. Based on observations, interviews and record reviews Resident #13 was not interviewable. Refer to the telephone interview with the facility's primary care provider (PCP) on 04/21/25 at 10:35am. Refer to the interview with MA on 04/21/25 at 11:01am. Refer to the interview with a second MA on 05/21/25 at 11:30am. Refer to the interview with the Special Care Unit (SCU) Coordinator on 04/21/25 at 1:40pm Refer to the interview with the Health and Wellness Director (HWD) on 05/21/25 at 2:10pm. Refer to the interview with the Administrator on 05/21/25 at 3:15pm. 9. Review of Resident #14's current FL-2 dated 08/27/24 revealed: -Diagnoses included dementia, cognitive dysfunction and anxiety. -She had an order for a regular diet. Review of Resident #14's care plan dated 08/16/24 revealed she required extensive assistance with eating. Observation of Resident #14 during the breakfast	D 311		

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D 311	Continued From page 17 meal in the SCU on 05/21/25 at 8:00am revealed: -She was sitting in the dining room at a half-moon table with three other residents. -Resident #14 was served oatmeal, eggs, bacon, waffles and sliced apples. -There was a cup of juice, coffee and milk in front of her. -There was a PCA feeding her meal to her. -The PCA fed three additional residents at the same time. -She ate 20% of the oatmeal, 25% of the eggs, 50% of the bacon, 75% of the waffle and 50% of the apples. -She drank 10% of the milk, 10% of the water and 50% of the juice. Based on observations, interviews and record reviews Resident #14 was not interviewable. Refer to the telephone interview with the facility's primary care provider (PCP) on 04/21/25 at 10:35am. Refer to the interview with MA on 04/21/25 at 11:01am. Refer to the interview with a second MA on 05/21/25 at 11:30am. Refer to the interview with the Special Care Unit (SCU) Coordinator on 04/21/25 at 1:40pm Refer to the interview with the Health and Wellness Director (HWD) on 05/21/25 at 2:10pm. Refer to the interview with the Administrator on 05/21/25 at 3:15pm. Telephone interview with the facility's PCP on 04/21/25 at 10:35am revealed:	D 311		

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D 311	Continued From page 18 -He was fine with the facility staff's decision to assist a resident by feeding them at meals. -He looked at each resident individually and discussed with the Health and Wellness Director (HWD) if there was a need for an order to feed a resident or assist with eating. Interview with a medication aide (MA) on 04/21/25 at 11:01am revealed: -She was trained on how to feed residents during her personal care aide (PCA) training. -She had always cut up food and cued more than one resident at a time to eat. -She would feed a resident if she saw they were not eating on their own. -She was trained to sit in front of the resident when feeding them. -There was one staff at each table to feed, coax and assist residents at the table; there were 3 to 4 residents at a table. -She had not been told to feed residents individually; only one at a time. -She usually did not have to feed more than one resident at one time. -She could give one resident a fork with food on it and they would start to eat, or she would feed one or two bites to get them started. Interview with a second MA on 05/21/25 at 11:30am revealed: -She was trained about 10 years ago on how to feed residents. -She would sit at the table with four residents. -She did not always feed 2 residents at a time, but there were times when she fed multiple residents at the same table at the same time. -If more than two residents at a table needed to be fed then there would be two staff at the table. Interview with the Special Care Unit (SCU)	D 311		

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D 311	Continued From page 19 Coordinator on 04/21/25 at 1:40pm revealed: -She monitored meals in the SCU and the AL. -She looked to see if all the residents had food, the residents were being fed that needed to be fed and that their diets were being followed. -She was not aware staff could only feed one resident at a time. -She had seen staff feeding more than one resident at a time. Interview with the Health and Wellness Director (HWD) on 05/21/25 at 2:10pm revealed: -She monitored the dining rooms about once a day. -She did not know which residents needed feeding. -If the staff identified a resident was not eating or needed assistance with eating then she expected the staff to feed them. -She was not aware staff were supposed to provide individual feeding assistance and only feed one resident at a time. Interview with the Administrator on 05/21/25 at 3:15pm revealed: -He was not aware residents needed to be fed one at a time. -Staff fed residents as they saw the need. -Sometimes the staff had to feed more than one resident at a time. -He was not aware residents needed to be fed one at a time. -Moving forward he would begin to stagger mealtimes for residents to ensure the staff were providing individual feeding assistance for residents.	D 311		