STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043029	A. BUILDING: _____ B. WING _____	R 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE CARE ASSISTED LIVING	431 JUNNY ROAD ANGIER, NC 27501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 08/12/25.	D 000		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure an accurate portion size was served to the residents during their lunch meal. The findings are: Review of the Healthy U.S. Dietary Pattern for Adults Ages 60 and Older based on the dietary guidelines revealed 5 to 6 ounces of meat should be served per day. Review of the facility's menu for lunch on 08/12/25 revealed 3 ounces of pot roast were to be served.	D 299		

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D 299	Continued From page 1 Observation of the lunch meal on 08/12/25 at 12:34pm revealed: -There were significantly small portions of pot roast served to the residents. -The pot roast served was less than 3 ounces. -The cook used a spoon to serve the portions on the plates. -The surveyor prompted the cook to add additional roast to the resident's plates. Interview with a resident on 08/12/25 at 2:57pm revealed: -He did not receive enough food today for lunch. -He requested a second portion, but the staff told him the food cart was gone and would not get him more food. -Some days they served enough food and some days they did not. Interview with the cook on 08/12/25 at 12:34pm revealed: -He used the spoon to serve the pot roast. -He did not know how much of the roast he was supposed to serve. -He did not know why he served the small portions of the roast to the residents. Interview with the Administrator on 08/12/25 at 12:45pm revealed: -The portion size of the roast was too small. -The cook should have served the residents a palm hand size of the roast. -The cooks had serving utensils to serve the correct amount of food. -She did not know why the cook did not serve the correct portion size for the roast.	D 299		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D 310		

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D 310	Continued From page 2 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 1 sampled resident (#2) who had a physician's order for a pureed diet. The findings are: Review of Resident #2's current FL-2 dated 09/16/24 revealed diagnoses included type 2 diabetes, history of diarrhea, and failure to thrive. Review of Resident #2's signed diet order dated 04/22/25 revealed an order for pureed. (A pureed diet is blended to smooth, pudding like consistency for individuals with difficulty swallowing). Observation of the refrigerator with a list of residents on special diets in the kitchen during the initial tour on 08/12/25 at 8:41am revealed Resident #2's diet order was pureed. Review of the facility's puree menu for breakfast on 08/12/25 revealed pureed hot cereal, pureed banana, pureed scrambled eggs, and a pureed waffle. Observation of Resident #2's breakfast plate on 08/12/25 at 8:42am revealed: -There were scrambled eggs, applesauce and	D 310		

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D 310	Continued From page 3	D 310		

oatmeal.
-The oatmeal had chunks in it.
-The scrambled eggs and the oatmeal were not pureed.

Second observation of Resident #2's breakfast plate on 08/12/25 at 8:48am revealed:
-The plate was delivered to the resident.
-A personal care aide (PCA) offered feeding assistance to the resident.
-The PCA fed Resident #2 the applesauce on his plate.

Interview with a PCA on 08/12/25 at 8:48am revealed:
-Resident #2 was supposed to be served a pureed diet.
-The scrambled eggs and oatmeal on Resident #2's breakfast plate was not pureed.
-She should have told the cook she needed a pureed breakfast meal for Resident #2.

Third observation of Resident #2's breakfast plate on 08/12/25 at 8:51am revealed the PCA stopped feeding the applesauce to Resident #2 and left to inform the cook she needed a pureed breakfast meal.

Interview with a cook on 08/12/25 between 9:00am and 9:15am revealed:
-The scrambled eggs were pureed.
-She did not know the scrambled eggs had to have a smooth consistency.
-She may not have left the scrambled eggs in the blender long enough.
-She had been working as a cook with the facility for 8 months.
-She did not remember her training on a pureed diet.
-She thought the scrambled eggs she served

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D 310	Continued From page 4 Resident #2 were okay if he could chew them. Interview with the Administrator on 08/12/25 at 12:45pm revealed: -The morning cook was responsible for training the other cooks. -She expected the cooks to follow the menus as they were. Interview with Resident #2's primary care provider (PCP) on 08/12/25 at 12:28pm revealed: -Resident #2 had difficulty swallowing. -He was at risk for choking, aspiration, and/or aspiration pneumonia if he received a regular meal.	D 310		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide 14 hours of planned group activities per week for active involvement of residents. The findings are: Observation of the facility on 08/12/25 from 8:40am to 3:30pm revealed: -There was no August 2025 activities calendar posted in common areas or in resident rooms. -There was a June 2025 activities calendar	D 317		

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D 317	Continued From page 5	D 317		

posted on a bulletin board in the hallway.
-There were no activities offered to residents by facility staff.

Interview with a resident on 08/12/25 at 10:05am revealed:
-There were no consistently scheduled, daily activities led by staff at the facility.
-When asked about activities for the day, the resident stated "you're seeing it" and gestured towards the living room TV.

Interview with a second resident on 08/12/25 at 11:05am revealed:
-There were no regularly scheduled activities at the facility.
-The residents played bingo led by the facility approximately once a month and made occasional crafts.
-She would like to play bingo and other games more frequently.

Interview with a personal care aide (PCA) on 08/12/25 at 11:00am revealed:
-There were some activities at the facility, but she could not say what the schedule was or how often activities were scheduled.
-She did not participate in activities or encourage residents to participate.

Interview with the facility Administrator on 08/12/25 at 12:40pm revealed:
-The facility's Activity Director was currently on vacation.
-She confirmed that no activities occurred today, 08/12/25, for the residents because facility staff were too busy.
-She had an August 2025 activities calendar developed and needed to post it.
-She had been too busy to post the August 2025

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D 317	Continued From page 6 activities calendar in the facility. -Residents should have been encouraged to attend at least 14 hours of scheduled activities available each week and the current schedule should be provided for residents to view.	D 317		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to provide dignity and respect for a resident as evidence by blending all the resident's food together due to his diet order for a pureed diet (#2). The findings are: Review of Resident #2's current FL-2 dated 09/16/24 revealed diagnoses included type 2 diabetes, history of diarrhea, and failure to thrive. Review of Resident #2's signed diet order dated 04/22/25 revealed an order for pureed. (A pureed diet is blended to smooth, pudding like consistency for individuals with difficulty swallowing). Review of the facility's puree menu for lunch on 08/12/25 revealed pureed pot roast, pureed diced potatoes, pureed sliced carrot, muffin, and pureed apples.	D 338		

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D 338	Continued From page 7 Observation of the lunch meal on 08/12/25 at 12:39pm revealed: -The cook served pot roast, a whole potato, bread, carrots, and berry pie. -The cook placed the carrots, potatoes, bread, pot roast, strawberries, blue berries, berry pie inside the blender. -The cook blended the food. Interview with the cook on 08/12/25 at 12:39pm revealed: -The food in the blender was for Resident #2. -He felt it was wrong to puree all of Resident #2's food together. -He was told by the cook who trained him to puree all the food together. Interview with the Administrator on 08/12/25 at 12:45pm revealed: -The cooks were not to puree Resident #2's food all together. -Resident #2's food should be served to him individually. -She expected the cooks to follow the menu. -The menu did not state to puree all the food together.	D 338		