STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 survey from 07/30/25 to 08/01/25.	D 000	Responses to the cited deficiencies do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared solely as a matter of compliance with the State law.	
D 074	10A NCAC 13F .0306 (a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings that are clean, safe, and functional; 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 ensure the floors were kept clean in the kitchen. The findings are: Observation of the floor in the kitchen between the stove and fryers on 07/30/25 at 10:20am revealed there was brown and black grease buildup both on the floor and on the sides of the	D 074	10A NCAC 13F .0306 Housekeeping And Furnishings Executive Director to implement a routine kitchen cleaning schedule. ED will conduct training with Dietary Manager and staff on routine cleaning schedule. ED will conduct twice weekly walk throughs of the kitchen for 4 weeks and at least weekly therafter. Executive Director will conduct training with DM and staff on use of appropriate cleaning chemicals inculding ordering procedures of chemicals and other cleaning supplies. ED will conduct weekly inventory of cleaning chemicals for 4 weeks then twice monthly therafter.	8/26/25 8/26/25 8/26/25 8/26/25 8/26/25

Reviewed and Acknowledged K.M. 09/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 074	Continued From page 1 fryers and stove/oven. Second observation of the floor in the kitchen on 07/31/25 at 10:50am revealed the same brown and black grease buildup was present. Interview with a dietary aide on 08/01/25 at 11:25am revealed: -There was no set cleaning schedule for the kitchen. -One of his responsibilities was to mop the kitchen floors daily in the mornings and afternoons. Interview with the Dietary Manager on 07/30/25 at 10:30am revealed: -She needed a special degreaser to remove the buildup between the fryers and the stove. -There were two full time cooks, including herself and two dietary aides. -There was no set cleaning schedule, but she expected staff to clean daily and weekly. Second interview with the Dietary Manager on 08/01/25 at 11:32am revealed: -She expected the facility's kitchen to be cleaned daily, including mopping the floors. -The cook was responsible for cleaning the steam table, stoves, preparation tables and the floors. -Staff tried to clean the floors, but the facility had recently changed chemical companies, and the new company was no longer supplying a degreaser. -The Administrator ordered all chemicals and she had told the Administrator several times that she needed a degreaser for the kitchen floor but was unable to recall the dates. Interview with the Regional Vice President of Operations in place of the Administrator on	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 074	Continued From page 2 08/01/25 at 5:26pm revealed: -She expected the kitchen floors to always be clean. -The Dietary Manager could order her own degreaser without the Administrator's approval.	D 074		
D 194	10A NCAC 13F .0608 (a)(b) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents (a) Each facility with a census of 21 or more residents shall have staff on duty to meet the needs of the residents. (b) In addition to the requirement in Paragraph (a) of this Rule, each facility with a census of 21 or more residents shall comply with the following staffing requirements: (1) On first shift and second shift, the total aide duty hours shall be at least: (A) 16 hours of aide duty for facilities with a census of 21 to 40 residents. (B) 20 hours of aide duty for facilities with a census of 41 to 50 residents. (C) 24 hours of aide duty for facilities with a census of 51 to 60 residents. (D) 28 hours of aide duty for facilities with a census of 61 to 70 residents. (E) 32 hours of aide duty for facilities with a census of 71 to 80 residents. (F) 36 hours of aide duty for facilities with a census of 81 to 90 residents. (G) 40 hours of aide duty for facilities with a census of 91 to 100 residents. (H) 44 hours of aide duty for facilities with a census of 101 to 110 residents. (I) 48 hours of aide duty for facilities with a census of 111 to 120 residents.	D 194	RVPO to conduct training on rule area 10A NCAC 13F .0608 with ED, Care Managers, and/or designees. ED will audit weekly staff schedule for staffing compliance weekly and for 4 weeks then at least bi-monthly thereafter	8/30/25 8/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 194	Continued From page 3 (J) 52 hours of aide duty for facilities with a census of 121 to 130 residents. (K) 56 hours of aide duty for facilities with a census of 131 to 140 residents. (L) 60 hours of aide duty for facilities with a census of 141 to 150 residents. (M) 64 hours of aide duty for facilities with a census of 151 to 160 residents. (N) 68 hours of aide duty for facilities with a census of 161 to 170 residents. (O) 72 hours of aide duty for facilities with a census of 171 to 180 residents. (P) 76 hours of aide duty for facilities with a census of 181 to 190 residents. (Q) 80 hours of aide duty for facilities with a census of 191 to 200 residents. (R) 84 hours of aide duty for facilities with a census of 201 to 210 residents. (S) 88 hours of aide duty for facilities with a census of 211 to 220 residents. (T) 92 hours of aide duty for facilities with a census of 221 to 230 residents. (U) 96 hours of aide duty for facilities with a census of 231 to 240 residents. (2) On third shift, the total aide duty hours shall be at least: (A) 8 hours of aide duty for facilities with a census of 21 to 30 residents. (B) 16 hours of aide duty for facilities with a census of 31 to 60 residents. (C) 24 hours of aide duty for facilities with a census of 61 to 90 residents. (D) 32 hours of aide duty for facilities with a census of 91 to 120 residents. (E) 40 hours of aide duty for facilities with a census of 121 to 150 residents. (F) 48 hours of aide duty for facilities with a census of 151 to 180 residents. (G) 56 hours of aide duty for facilities with a	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 194	Continued From page 4 census of 181 to 210 residents. (H) 64 hours of aide duty for facilities with a census of 211 to 240 residents. (3) If the Department determines the needs of the residents at a facility are not being met by staffing requirements of Paragraph (b) of this Rule, the Department shall require the facility to employ staff to meet the needs of the residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to meet the minimum required aide hours to meet the needs of residents residing in the Assisted Living (AL) unit for 7 of 9 sampled shifts from 07/25/25 to 07/27/25. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was an Adult Care Home with a capacity for 78 residents, 20 of which were Special Care Unit (SCU) beds. Review of the facility's census dated 07/25/25 revealed a census of 47 residents residing in the AL. Review of the census and time punch cards for staff on 07/25/25 revealed:	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 194	Continued From page 5 -There was a census of 48 AL residents, which required 20 aide hours on first and second shift. -There was a total of 18 aide hours provided on first shift leaving a shortage of 2 aide hours. -There was a total of 19 aide hours provided on second shift leaving a shortage of 1 aide hour. Review of the census and time punch cards for staff on 07/26/25 revealed: -There was a census of 48 AL residents, which required 20 aide hours on second shift, and which required 16 aide hours on third shift. -There was a total of 13.5 aide hours provided on second shift leaving a shortage of 6.5 aide hours. -There was a total of 13 aide hours provided on second shift leaving a shortage of 3 aide hours. Review of the census and time punch cards for staff on 07/27/25 revealed: -There was a census of 48 AL residents, which required 20 aide hours on first and second shift, and which required 16 aide hours on third shift. -There was a total of 18.5 aide hours provided on first shift leaving a shortage of 1.5 aide hours. -There was a total of 10.5 aide hours provided on second shift leaving a shortage of 9.5 aide hours. -There was a total of 4.50 aide hours provided on third shift leaving a shortage of 11.50 aide hours. Interview with a resident on 07/30/25 at 9:20am revealed: -He did not know what happened last weekend with the staff, but they did not answer the call bell when he called for help. -It took 45 minutes for a response from staff last weekend; when staff finally responded to the call bell, staff said they would be back but did not return. -The facility was short staffed a lot and especially during the weekends.	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 194	Continued From page 6 Interview with a second resident on 07/30/25 at 9:50am revealed: -The facility was short staffed a lot and especially during the weekends. -She had waited close to an hour for an aide to respond to her call light several times in the evenings and on the weekends. -She had never seen more than 1 personal care aide (PCA) working at the facility on the weekend after dinner time. Interview with a resident's responsible party on 08/01/25 at 8:40am revealed: -The facility was "short staffed a lot". -There was only one PCA in the AL during the evenings over the last weekend. Interview with a PCA on 08/01/25 at 2:00pm revealed: -She was working on the AL side of the facility today but switched back and forth between the AL and the SCU due to the facility being short on staff at times. -There was another PCA working with her on the AL side over the weekend, but she was pulled to the SCU, leaving her the only PCA on the AL side with over 48 residents on Saturday evening. -Some days they were fully staffed, and other days they were not. -She worked first shift and had come to work several times on the weekends and there would not be enough PCAs in the facility. Interview with a second PCA on 08/01/25 at 2:41pm revealed: -She worked first shift and would stay over a few hours on second shift when needed related to the red dot system the facility management had in place for staff coverage.	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 194	Continued From page 7 -The staff rotated from the SCU to the AL on the schedule. -There was enough staff on first shift, but not always enough staff on second shift. -When she stayed over and worked second shift, she would help with the residents who were visually impaired because they required more assistance than the other residents. Interview with a medication aide (MA) on 07/31/25 at 1:50pm revealed: -The facility did not have a full staff on some days. -Some staff would come in late, call out, or not show up for work because they took advantage of the red dot system (a red dot by the staff's name required them to stay for next shift) that facility management had put in place for staff coverage. -The weekends were short staffed. Interview with the Resident Care Coordinator (RCC) on 08/01/25 at 4:25pm revealed: -PCAs and MAs were required to bathe, dress, clean and provide assistance to all residents as required by the residents' care plan. -She felt there was adequate staffing to meet the residents' needs. -She was not aware of a staffing shortage the previous weekend because she was on vacation. -Both she and the Special Care Unit Coordinator (SCUC) were responsible for covering staff shortages and alternated on-call duties weekly. -She encouraged staff to find their own coverage but would fill in if coverage could not be obtained. Interview with the Regional Vice President of Operations in place of the Administrator on 08/01/25 at 5:18pm revealed: -She expected care to be rendered whenever needed.	D 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 194	Continued From page 8 -She was not aware of a staffing shortage last weekend.	D 194		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents' ice supply was protected from contamination as evidenced by a scoop for the ice machine in the kitchen uncovered on top of the machine. The findings are: Initial tour of the kitchen on 07/30/25 at 10:30am revealed: -The kitchen contained one large ice machine that supplied the entire facility. -The scoop for the ice machine was lying uncovered on top of the machine. Second observation of the kitchen on 07/31/2025	D 282	ED will conduct training with DM and dietary staff on ice scoop storage and sanitizing requirements. ED and/or designee will ensure ice scoops are stored in proper container when not in use. ED and/or DM will monitor ice scoop storage at random times daily x 4 weeks and at least weekly thereafter.	8/28/25 8/28/25 8/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 282	Continued From page 9 at 8:15am revealed the ice scoop was lying uncovered on top of the ice machine. Interview with a dietary aide on 08/01/25 revealed: -He was unaware that the ice scoop was supposed to be covered when outside the machine. -He ran the ice scoop through the dishwasher once daily. Interview with the Dietary Manager on 07/30/2025 at 10:30am revealed: -She was aware that the ice scoop needed to be covered when outside the machine, but she did not have a cover for it. -She expected the ice scoop to be run through the dishwasher at least once daily. Interview with the Regional Vice President of Operations in place of the Administrator on 08/01/25 at 5:26pm revealed: -She was aware that the ice scoop needed to be covered when outside the ice machine. -She was not aware there was no cover for the ice scoop.	D 282		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages.	D 306	ED will conduct training with DM and dietary staff on meal and beverage services. ED, RCC, SCC, and/or designee will monitor meals to ensure appropriate beverages are served x 4 weeks and then weekly thereafter.	8/28/25 8/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 306	Continued From page 10	D 306		

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure water was served at each meal for 31 of 37 assisted living (AL) residents, in addition to other beverages.

The findings are:

Observation of the lunch meal service on 07/30/25 between 12:33pm and 1:14pm revealed:
-There were 37 residents present for the lunch meal service.
-The beverages had been placed on the dining tables prior to the residents being seated.
-Six glasses of water had been placed on the dining tables for 6 residents, and all the other glasses contained other beverages.
-No other residents were served water.

Observation of the breakfast meal service on 07/31/25 between 7:35am and 8:01am revealed:
-There were 35 residents present for the breakfast meal service.
-Six glasses of water had been placed on the dining tables for 6 residents only.
-Other beverages on each table included milk, coffee and juice.
-No other residents were served water.

Interview with a resident on 07/31/25 at 7:43am:
-Beverages served with meals usually included coffee and tea and occasionally juice.
-If she wanted water with her meals, she had to ask for it.
-She would drink water with every meal if it was served to her with each meal.

Interview with a second resident on 07/31/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 306	Continued From page 11	D 306		

7:51am revealed:
-Residents were not served water with each meal.
-She would drink water with her meals if it was served to her.
-She drank what was served to her and did not ask for water.

Interview with a dietary aide on 08/01/25 at 11:25am revealed:
-Beverages were placed on the tables prior to the residents arriving in the dining room.
-He knew what each resident liked to drink and placed the drinks on the tables according to the residents' preferences.
-The residents drank the same beverages every day.
-There were only 6 residents who drank water, and he knew that water was to be served at every meal.

Interview with a personal care aide (PCA) on 08/01/25 at 11:05am revealed:
-She assisted in the dining room during meals.
-Beverages were already on the tables in the dining room when residents arrived for meals.
-Water was not placed on every table or offered to all residents at every meal.
-A few residents were served water, but the other residents preferred tea or coffee.
-She did not know water should have been served to all residents with each meal.

Interview with the Dietary Manager (DM) on 08/01/25 at 11:32am revealed she expected her staff to serve water to anyone who requested it.

Interview with the Resident Care Coordinator (RCC) on 08/01/25 at 4:42pm revealed:
-PCAs and medication aides (MA) passed out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 306	Continued From page 12 meal trays, monitored residents while they were eating and refilled their drinks. -PCAs and MAs did not set up tables in the dining room. -PCAs and MAs refilled residents' drinks upon request. -She expected staff to supply drinks but was unaware that water was to be served at every meal. Interview with the Regional Vice President of Operations in place of the Administrator on 08/01/25 at 5:26pm revealed: -She knew residents were to be served water daily with each meal and expected staff to do so. -She did not know all residents were not being served water with each meal.	D 306		
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, interviews, and record reviews, the facility failed to ensure 3 of 5 sampled residents (#1, #3, #5) were treated with respect, consideration, and dignity and residents' rights were maintained. The findings are: 1. Review of Resident #3's current FL2 dated 07/11/25 revealed: -Diagnoses included attention deficit disorder,	D 338	ED will arrange resident rights training with ombudsman at first available date. Community staff will recieve training from CNC RN on "Who am I?" "Call Bell response procedures" "Providing personal care" ED, RCC, SCC and/or designee will implement a "Who am I" form and binder which contains information that is available to care staff regarding personal care needs	10/15/25 8/24/25 8/26/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 338	Continued From page 13	D 338		

bipolar 1 disorder, benign prostatic hyperplasia, depression, hyperlipidemia, hypertension, and stroke determined by clinical assessment.
-He was continent of bowel and bladder.

Review of Resident #3's care plan dated 11/25/24 revealed:
-He was continent of both bowel and bladder and was independent with transfers and toileting.
-He was oriented with no memory problems indicated.

Interview with Resident #3 during the initial tour on 07/30/25 at 9:20am revealed:
-None of the regular staff helped him get changed last weekend; a physical therapist helped him get changed.
-Staff let him sit in urine and feces all day Saturday, 07/26/25.
-He did not know what happened last weekend with the staff, but they did not answer the call bell when he called for help.
-It took 45 minutes for a response from staff last weekend; when staff finally responded to the call bell, staff said they would be back but did not return.

Second interview with Resident #3 on 08/01/25 at 11:27am revealed:
-Calls bells were rarely answered in less than 30 minutes and were sometimes not answered at all, especially at night and on the weekends.
-He had recently begun requiring more assistance due to health changes but could still tell when he had to use the bathroom.
-He wore pull ups only and not diapers for occasional bladder leakage.

Interview with a personal care aide (PCA) on 08/01/25 at 2:13pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 338	Continued From page 14 -She assisted Resident #3 with toileting, transported him in his wheelchair, made his bed and did his laundry. -Resident #3's needs had increased recently, and he was now incontinent of bowel and bladder. -There were sometimes not enough staff to help residents. -PCAs and medication aides (MA) were responsible for toileting and other care areas, but some MAs felt they should only pass medications. -Resident #3 wet his bed and his clothes often. -There was only one PCA and one MA assigned to Resident #3's hallway on most days but there should be more due to heavy care. Interview with a MA on 08/01/25 at 2:42pm revealed: -She provided assistance with activities of daily living (ADL) every day. -She had assisted Resident #3 with transfers, showering and dressing. -Staffing had been cut by nearly half and this had adversely affected resident care. Interview with the Resident Care Coordinator (RCC) on 08/01/25 at 4:25pm revealed: -PCAs and MAs were required to bathe, dress, clean and provide all assistance to Resident #3 as required. -She felt there was adequate staffing to meet the residents' needs. -She was not aware of a staffing shortage the previous weekend because she was on vacation. -Both she and the Special Care Unit Coordinator (SCUC) were responsible for covering staff shortages and alternated on-call duties weekly. -She encouraged staff to find their own coverage but would fill in if coverage could not be obtained.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 338	Continued From page 15	D 338		

Interview with the Regional Vice President of Operations in place of the Administrator on 08/01/25 at 5:18pm revealed:
-She expected care to be rendered whenever needed.
-She was not aware of a staffing shortage last weekend.

2. Review of Resident #5's FL2 dated 01/28/25 revealed:
-Diagnoses included atrial fibrillation, congestive heart failure, atherosclerotic heart disease, morbid obesity, presence of prosthetic heart valve, stage III chronic kidney disease, and hypertension.
-She was continent of bowel and bladder.

Review of Resident #5's care plan dated 02/19/25 revealed:
-She was continent of bowel with occasional incontinence of bladder and required limited assistance with transfers and toileting.
-She was oriented with no memory problems indicated.

Observation of the hallway on 07/30/25 between 12:49pm and 1:12pm revealed:
-Resident #5's call light came on at approximately 12:52pm.
-A personal care aide (PCA) was passing meal trays to residents in their rooms and entered Resident #5's room at approximately 1:02pm and exited at 1:03pm.

Interview with Resident #5 on 07/30/25 at 12:53pm revealed she activated her call bell because she needed to go to the bathroom before lunch.

Second interview with Resident #5 on 07/30/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 338	Continued From page 16 1:05pm revealed: -The PCA delivered her lunch meal and told the resident she did not have time to take her to the bathroom. -Resident #5 had her lunch meal sitting on the seat of her rolling walker and asked surveyor, "Could you eat a meal if had to use the bathroom? I cannot eat this because I am soaked." Third interview with Resident #5 on 07/31/25 at 7:50am revealed: -She wetted herself daily waiting on assistance from staff. -She took a fluid pill daily, so she urinated often. -It took "forever" for staff to answer call bells, and they were sometimes rude because they felt rushed and bothered and because she needed so much assistance. Interview with Resident #5's primary care provider (PCP) on 08/01/25 at 10:07am revealed: -Resident #5's diuretic medication increased urination. -Resident #5 needed assistance in all areas of personal care except eating and she expected facility staff to help in all areas of need, especially bathing and toileting. Interview with a PCA on 08/01/25 at 2:13pm revealed: -She was told by management staff that she must always remain in the dining room during meals. -Call bells made a sound at the nursing station and the medication aides (MAs) alerted PCAs that assistance was needed during mealtimes. -MAs were on the halls passing meds during meals but rarely provided resident assistance. -She provided toileting assistance to Resident #5 daily.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 338	Continued From page 17	D 338		

-She never witnessed any staff member refuse care to a resident.
-There were sometimes not enough staff to help residents.
-There was only one PCA and one MA assigned to Resident #5's hallway on most days but there should be more due to heavy care.

Interview with a MA on 08/01/25 at 2:42pm revealed:
-She provided toileting assistance to Resident #5 when she was assigned as a PCA.
-PCAs were required to remain in the dining room during meals.
-MAs notified PCAs when call lights were activated or the MA provided assistance.
-She had never witnessed any staff member refuse care to a resident.
-Staffing had been cut by nearly half and this had adversely affected resident care.

Interview with the Special Care Unit Coordinator (SCUC) on 08/01/25 at 5:00pm revealed:
-She expected PCAs to remain in the dining room during meals and provide assistance to residents after the meal.
-She did not expect staff to ever tell a resident they did not have time to assist, and it was unacceptable for a resident to eat while soiled or wet.

Interview with the Resident Care Coordinator (RCC) on 08/01/25 at 4:25pm revealed:
-She expected at least one PCA to remain in the dining room during meals and a PCA would pass meal trays on the hall at the end of each meal.
-MAs monitored call lights during meals and management assisted when needed.
-She would not expect staff to toilet residents during meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 338	Continued From page 18	D 338		

-She had never witnessed any staff member refuse care to a resident.

Interview with the Vice President of Operations in place of the Administrator on 08/01/25 at 5:18pm revealed:
-She was not aware that care was not rendered to Resident #5, and it was her expectation that care was rendered during meals.
-She expected PCAs to be in the dining room during meals, but a PCA should have told the resident that they would help after trays were passed or get another staff member to assist.

3. Review of Resident #1's FL2 dated 03/26/25 revealed:
-Diagnoses included dementia with behaviors, diabetes mellitus type 2, insomnia, constipation, and dysphagia.
-She was incontinent of bowel and bladder.

Review of Resident #1's care plan dated 03/25/25 revealed:
-She was incontinent of both bowel and bladder and required extensive assistance with toileting, bathing, dressing, and grooming.
-She was constantly disoriented and required memory care assistance.

Interview with Resident #1's responsible party on 08/01/25 at 1:30pm revealed:
-The facility was short staffed and the personal care aides (PCA) took a long time to answer call bells.
-She had changed her mother's clothes multiple times because "she felt made to do her mother's care because she had visited her mother."
-She had visited her mother for hours and had changed her clothes, provided bathing assistance, and brushed her hair because she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 338	Continued From page 19	D 338		

felt like it was not being done for her mother.
-She had not reported her concern because she had not wanted retaliation from the staff toward her mother if she spoke out.

Interview with a PCA on 08/01/25 at 2:00pm revealed:
-Some days they were fully staffed, and other days they were not.
-She worked when there were not enough PCAs in the SCU and had relied on residents' family members to help her while she attended to other residents' care.
-She was not aware a family member felt obligated to provide a resident's care in the SCU because the resident's family member felt the resident was not being dressed according to her needs.

Interview with a second PCA on 08/01/25 at 2:41pm revealed:
-The staff rotated from the SCU to the AL on the schedule.
-There was enough staff on first shift, but not always enough staff on second shift.
-She was not aware a resident's family member had felt obligated to care for her mother and was not aware the resident was not being dressed as needed.

Interview with a medication aide (MA) on 07/31/25 at 1:50pm revealed:
-The facility did not have a full staff on some days.
-Some staff would come in late, call out, or not show up for work and the weekends were short staffed.
-She would not be surprised if a family member had provided care for a resident due to a staffing shortage of PCAs at times in the SCU.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 338	Continued From page 20 Interview with the Special Care Unit Coordinator (SCUC) on 08/01/25 at 4:57pm revealed: -PCAs and MAs were required to bathe, dress, clean and provide all assistance to all residents as required by the residents' care plan. -She felt there was adequate staffing to meet the residents' needs. -She was not aware of a staffing shortage at any time for the SCU and expected to be informed by the PCAs and MAs if there was a staffing shortage. -She was not aware any SCU resident had gone without being dressed, bathed, or any type of care. -No residents or residents' family members should ever feel obligated to provide their own care and the PCAs and MAs should have provided residents' care according to their assessed care needs on their care plan. Interview with the Regional Vice President of Operations in place of the Administrator on 08/01/25 at 5:18pm revealed: -She was not aware of a staffing shortage for PCAs in the SCU. -She expected care to be rendered whenever needed by PCAs and MAs and family members not to feel obligated to ever provide care for the residents at the facility. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.	D 338		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358	ED, RCC, SCC, and MAs will complete medication administration training to include pharmacy policies and procedures, as related to ordering medications.	9/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 358	Continued From page 21 (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents including an antidepressant (#4). The findings are: 1. Review of Resident #4's current FL2 dated 02/24/25 revealed: -Diagnoses included diabetes mellitus and major depressive disorder. -There was an order for sertraline (used to treat depression) 50mg daily. Review of Resident #4's July 2025 electronic medication administration record (eMAR) from 07/01/25 to 07/30/25 revealed: -There was an entry for sertraline 50mg tablet take one tablet daily for depression. -There was documentation sertraline was not administered from 07/08/25 to 07/12/25 and on 07/20/25 with the comment "awaiting pharmacy". Observation of the medications on hand for Resident #4 on 08/01/25 at 11:24am revealed there was a multiple medication dose pack dispensed on 07/24/25 containing sertraline 50mg with 3 of 7 tablets remaining available for administration.	D 358	MAR to cart audit to be completed by ED, RCC, SCC and/or designees to ensure compliance. RCC/SCC and/or designee will review medication ordering needs. will review new orders and medication delivery sheets twice weekly for the next 30 days and at least weekly thereafter.	9/10/25 9/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 358	Continued From page 22 Attempted telephone interview with a pharmacist from the facility's contracted pharmacy on 08/01/25 at 4:07pm unsuccessful. Telephone interview with Resident #4's psychiatric provider on 08/01/25 at 10:47am revealed: -She did not know Resident #4's sertraline was not administered for 6 of 30 days in July 2025, 07/08/25 to 07/12/25 and 07/20/25. -There were no side effects of Resident #4 not being administered sertraline 50mg for 6 days in July 2025. -She expected the facility to administer sertraline to Resident #4 as ordered. Interview with a medication aide (MA) on 08/01/25 at 2:30pm revealed: -She administered medications to Resident #4. -She had requested sertraline 50mg for Resident #4 for two or three days in a row in July 2025 but it took a few days for the medication to arrive from the pharmacy. Interview with the MA/Supervisor on 08/01/25 at 3:00pm revealed: -Sometimes it took a few days for medication to arrive from the pharmacy after it was ordered. -If a medication was ordered on a Friday, it may not arrive to the facility until the following Monday or Tuesday. -She tried to call the facility's backup pharmacy if she was waiting on a resident's medication to arrive and would let the Resident Care Coordinator (RCC) know if she still had issues with the medication. Interview with the RCC on 08/01/25 at 4:25pm revealed: -She did not know Resident #4's sertraline was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 358	Continued From page 23 not administered for 6 of 30 doses in July 2025. -She expected staff to call the pharmacy if Resident #4's sertraline was not available and to notify her or the Administrator if there was a problem with the medication. -Staff usually told her if they had trouble with a resident's medication arriving from the pharmacy or staff would call the pharmacy on their own. -Medication cart audits were completed weekly, and the most recent audit was completed two weeks prior to 08/01/25. -A medication cart audit consisted of checking the medication carts and ensuring residents had medication on the cart available for administration. Interview with the Regional Vice President of Operations in place of the Administrator on 08/01/25 at 5:20pm revealed: -She did not know Resident #4's sertraline was not administered for 6 of 30 doses in July 2025. -She expected MAs to follow physician orders and facility policies. -MAs were responsible to administer medications as ordered by the provider. Attempted interview with Resident #4 on 08/01/25 at 2:30pm unsuccessful due to resident refused to be interviewed.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order;	D 367	ED, RCC, SCC, and MAs will complete medication administration training to include proper documents of orders and results. RCC/SCC, ED, and/or designee to complete MAR to PO to ensure orders are recorded correctly with matching documentation.	9/05/25 9/05/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 367	Continued From page 24 (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#4) including inaccurate documentation of a fast-acting insulin. The findings are: Review of Resident #4's current FL2 dated 02/24/25 revealed diagnoses included diabetes mellitus and major depressive disorder. Review of Resident #4's signed physician's order dated 05/16/25 revealed there was an order for insulin aspart (a medication used to treat diabetes mellitus) 100 unit/mL pen (3mL) inject subcutaneously twice daily, check finger stick blood sugar (FSBS) twice daily at 6:30am and 4:30pm. If FSBS was greater than 250, inject 10 units subcutaneously. If FSBS was greater than	D 367	RCC/SCC and/or designee to bring internal QI reports to daily standup meetings for ED to review new order documentation 3 times a week for 4 weeks and then at least weekly ongoing.	9/08/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 367	Continued From page 25 450, inject an additional 4 units for a total of 14 units. Review of Resident #4's progress note dated 05/14/25 revealed there was a hemoglobin A1C (a blood test that provides an average of blood sugar levels over the past 2 to 3 months) result of 6.3% dated 03/20/25. Review of Resident #4's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for insulin aspart 100 unit/ml, check blood sugar (BS) twice daily at 6:30am and 4:30pm. If BS over 250, inject 10 units subcutaneously. If BS over 450, inject an additional 4 units for total 14 units subcutaneously. Contact provider if BS less than 80 or greater than 450. -There was documentation insulin aspart was administered when it should have been held on 05/12/25, 05/17/25, 05/20/25, 05/26/25, 05/27/25, and 05/31/25 at 7:00am. -There was documentation insulin aspart was administered when it should have been held on 05/04/25, 05/06/25, 05/13/25, 05/15/25, 05/18/25, 05/22/25 at 5:00pm. -Resident #4's FSBS ranged from 93-429. Review of Resident #4's June 2025 eMAR from 07/01/25 to 07/16/25 revealed: -There was an entry for insulin aspart 100 unit/ml, check blood sugar (BS) twice daily at 6:30am and 4:30pm. If BS over 250, inject 10 units subcutaneously. If BS over 450, inject an additional 4 units for total 14 units subcutaneously. Contact provider if BS less than 80 or greater than 450. -There was documentation insulin aspart was administered when it should have been held on	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 367	Continued From page 26 06/03/25, 06/06/25, 06/08/25, 06/09/25, 06/14/25 and 06/22/25 at 7:00am. -There was documentation insulin aspart was administered when it should have been held on 06/12/25, 06/15/25, 06/17/25, and 06/21/25 at 5:00pm. -Resident #4's FSBS ranged from 93-531. Review of Resident #4's July 2025 eMAR from 07/01/25 to 07/30/25 revealed: -There was an entry for insulin aspart 100 unit/ml, check blood sugar (BS) twice daily at 6:30am and 4:30pm. If BS over 250, inject 10 units subcutaneously. If BS over 450, inject an additional 4 units for total 14 units subcutaneously. Contact provider if BS less than 80 or greater than 450. -There was documentation insulin aspart was administered when it should have been held on 07/01/25, 07/05/25, 07/06/25, 07/07/25, 07/15/25, 07/20/25, 07/21/25, 07/23/25, 07/24/25, 07/25/25, 07/26/25 and 07/29/25 at 7:00am. -There was documentation insulin aspart was administered when it should have been held on 07/24/25, 07/26/25 and 07/29/25 at 5:00pm. -Resident #4's FSBS ranged from 83-489. Observation of the medications on hand for Resident #4 on 08/01/25 at 11:24am revealed there was a new, undated and unopened insulin aspart pen available for administration. Attempted telephone interview with a pharmacist from the facility's contracted pharmacy on 08/01/25 at 4:07pm was unsuccessful. Interview with Resident #4's primary care provider (PCP) on 08/01/25 at 10:10am revealed: -She did not know there was documentation on the eMARs that Resident #4's insulin aspart was	D 367	Responses to the cited deficiencies do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared solely as a matter of compliance with the State law. 10A NCAC 13F .0306 Housekeeping And Furnishings Dietary Manager or desine e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 367	Continued From page 27	D 367		

administered when it should have been held for 12 of 62 opportunities in May 2025, 10 of 60 opportunities in June 2025 and 15 of 59 opportunities in July 2025.
-She would have expected the facility staff to document and administer medications as ordered.
-There was no adverse effect or outcome from Resident #4's insulin aspart.

Interview with a medication aide (MA) on 08/01/25 at 2:30pm revealed:
-She administered medications to Resident #4's sometimes.
-Resident #4's insulin aspart and check blood sugar orders were combined as one order entry on the eMAR.
-She knew Resident #4 was only administered insulin aspart if Resident #4's FSBS was above 250.
-She documented that she checked Resident #4's FSBS on 06/21/25 and it appeared that she had administered insulin aspart to Resident #4 when it should have been held, but she had not administered insulin aspart.
-There was nowhere on the eMAR to separately document if insulin aspart was administered to Resident #4 without making an eMAR comment.

Telephone interview with a second MA on 08/01/25 at 3:43pm revealed:
-She administered insulin to and checked Resident #4's FSBS.
-She only administered insulin when Resident #4's FSBS was above 250.
-She always checked Resident #4's FSBS before administering insulin.
-Resident #4 had never showed signs of low blood sugar, including weakness.
-She did not know she documented she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 367	Continued From page 28	D 367		

administered insulin aspart to Resident #4 when it should have been held six times in May 2025, two times in June 2025 and 3 times in July 2025.
-She was "clicking off" on the eMAR that she checked Resident #4's FSBS and it appeared that she also administered insulin aspart.
-She had never administered insulin to Resident #4 when Resident #4's FSBS was below 250.

Interview with a third MA on 08/01/25 at 3:55pm revealed:
-She administered insulin to Resident #4.
-Resident #4 was only administered insulin aspart if her FSBS was above 250.
-She never administered insulin when Resident #4's FSBS was below 250.
-She documented "not administered" for insulin aspart in a comment on the eMAR if Resident #4's FSBS was below 250.

Interview with the Resident Care Coordinator (RCC) on 08/01/25 at 4:25pm revealed:
-She had noticed on 07/28/25 that it appeared MAs were documenting they administered insulin aspart when it should have been held to Resident #4 because the FSBS and insulin aspart were one order entry on the eMAR.
-The pharmacy normally placed medication order entries on the eMAR but she could also put entries on the eMAR.
-Medication cart audits were normally completed weekly; a medication cart audit consisted of ensuring medication was available to be administered.
-The last medication cart audit was completed about two weeks ago, the week of 07/18/25.

Interview with the Regional Vice President of Operations in place of the Administrator on 08/01/25 at 5:20pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034114	A. BUILDING: _____ B. WING _____	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

(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 367	Continued From page 29 -She did not know some of the MAs were documenting they administered insulin aspart to Resident #4 when it should have been held 12 times in May 2025, 10 times in June 2025 and 15 times in July 2025. -She expected MAs to follow physician orders and facility policies. -MAs were responsible to accurately document medication administration on the eMAR. Attempted interview with Resident #4 on 08/01/25 at 2:30pm unsuccessful due to resident refused to be interviewed.	D 367		