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
	HAL034115	A. BUILDING: _____ B. WING _____	R 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERNER RIDGE ASSISTED LIVING	250 HOPKINS ROAD KERNERSVILLE, NC 27284

(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 a follow up survey from 08/26/25 through 08/27/25.	D 000	D 310 Kitchen staff will be inserviced on therapeutic diets and alternatives by 10-20-2025. Dietary Manager will check 10 plates before being served 3 times a week x 4 weeks then monthly and as needed. To ensure the right diet is being served.	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 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 serve therapeutic diets as ordered by the provider for 1 of 4 sampled residents (#6) with therapeutic diet orders for a finger food (FF) diet. The findings are: Review of Resident #6's current FL2 dated 05/20/25 revealed: -Diagnosis included dementia, unspecified emphysema, unspecified hypothyroidism, unspecified hyperlipidemia and unspecified anemia. -There was not a check beside the diet nor a specified diet written. Review of Resident #6's diet order form dated 04/09/25 revealed an order for a FF diet. Review of the therapeutic diet list posted in the kitchen revealed Resident #6 was to be served a FF diet.	D 310	Memory Care staff will be inserviced on therapeutic diets by 10-20-2025. MC director will monitor plates being served in MC 3 times a week x 4 weeks then monthly and as needed to ensure correct diet is being served.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE ED (X6) DATE 9/29/2025

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D 310	Continued From page 1 Review of the FF menu for the lunch meal service on 08/26/25 revealed Resident #6 was to be served grilled cheese finger bites, two ounces of French fries, and either fruit wedges or fruit bread. Observation of Resident #6's lunch meal service on 08/26/25 between 11:35am and 12:40pm revealed: -Resident #6 was served finger bite chicken tenders, French fries, and a half cup of peach cobbler. -Resident #6 ate 95% of his chicken tenders and French fries with no difficulty and consumed 90% of his beverages without difficulty. -Resident #6 ate 50% of his peach cobbler with difficulty because he spilled portions of his peach cobbler from his fork on the dining table. -Resident #6 was not supposed to have been served a half cup of peach cobbler and should have been served either fruit wedges or fruit bread without use of utensils. Review of the FF menu for the breakfast meal service on 08/27/25 revealed Resident #6 was to be served a pop tart, pieces of a cheese omelet, two half slices of toast and two sausage links. Observation of Resident #6's breakfast meal service on 08/27/25 between 7:15am and 8:20am revealed: -Resident #6 was served cereal in a bowl with milk, scrambled eggs, two half slices of toast and two sausage links. -Resident #6 ate 100% of his sausage links and toast with no difficulty and consumed 90% of his beverages without difficulty. -Resident #6 ate 50% of his cereal and 75% of his scrambled eggs with difficulty because he spilled portions of his cereal with milk and his	D 310	10	

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D 310	Continued From page 2	D 310		

scrambled eggs on the dining table.
-The Resident Care Director (RCD) provided Resident #6 with a fork for eating his scrambled eggs and Resident #6 expressed the preference to use his hands instead.
-Resident #6 scooped the scrambled eggs with difficulty because he missed portions on his plate and he dropped portions of his scrambled eggs from handling his fork unsteadily.
-Resident #6 was not supposed to have been served cereal and scrambled eggs and should have been served a pop tart and pieces of a cheese omelet without use of utensils.

Based on observations, interviews and record review, it was determined Resident #6 was not interviewable.

Interview with a personal care aide (PCA) from the SCU unit on 08/27/25 at 8:15am revealed:
-He assisted in the SCU dining room during meals.
-He was aware Resident #6 was on a FF diet.
-He was aware Resident #6 was served peach cobbler at the lunch meal service on 08/26/25 and was served cereal in a bowl and scrambled eggs at the breakfast meal service on 08/27/25.
-He was not aware Resident #6 should have been served either fruit wedges or fruit bread at the lunch meal service on 08/26/25 and should have been served a pop tart and pieces of a cheese omelet at the breakfast meal service on 08/27/25.
-He was not aware Resident #6 used utensils to eat his food during the lunch meal service on 08/26/25 and during the breakfast meal service during 08/27/25.
-He relied on dietary staff to provide meals for residents at meal services.

Interview with a cook on 08/27/25 at 8:20am

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D 310	Continued From page 3 revealed: -She or the Dietary Manager (DM) prepared each meal for the residents. -She was aware Resident #6 was on a FF diet. -She prepared Resident #6's breakfast meal on 08/26/25. -She served Resident #6 scrambled eggs at the breakfast meal on 08/27/25 and knew Resident #6 should have been served pieces of a cheese omelet but was rushed and did not pay attention. -She was not aware Resident #6 was served peach cobbler for the lunch meal on 08/26/25 because she had not worked during the lunch service. -She was not aware Resident #6 was served cereal in a bowl with milk because she had sent the cereal with the PCAs from the SCU on the dining cart. -She and the DM were responsible for preparing residents' meals according to the therapeutic menus and serving residents' diets as ordered. Interview with the DM on 08/27/25 at 8:30am revealed: -He or the cook prepared each meal for the residents. -He was aware Resident #6 was on a FF diet. -He and the cook prepared Resident #6's breakfast meal on 08/27/25 and he prepared Resident #6's lunch meal on 08/26/25. -He was not aware Resident #6 was served peach cobbler and had used utensils to eat his food at the lunch meal on 08/26/25. -He was aware Resident #6 was served scrambled eggs at the breakfast meal on 08/27/25 and knew Resident #6 should have been served pieces of a cheese omelet but was rushed and did not pay attention. -He and the cook were responsible for preparing residents' meals according to the therapeutic	D 310		

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D 310	Continued From page 4 menus and serving residents' diets as ordered. -He expected meals to be served according to the residents' diets as ordered. Interview with Resident #6's primary care provider (PCP) on 08/27/25 at 1:20pm revealed: -She ordered a FF diet for Resident #6 due to Resident #6's dementia. -She did not know Resident #6 was not served a FF diet according to the menu on 08/26/25 and 08/27/25 and used utensils to eat his food. -She expected the facility to serve diets as ordered for all residents and expected Resident #6 to be free of using utensils with meals that are prepared according to a FF diet. Interview with the RCD on 08/27/25 at 8:40am revealed: -She assisted in the SCU dining room during meals. -She was not aware Resident #6 was on a FF diet. -She was not aware Resident #6 was served peach cobbler at the lunch meal service on 08/26/25 because she had not worked in the SCU that day. -She was aware Resident #6 was served cereal and scrambled eggs at the breakfast meal service on 08/27/25 but she was not aware she should have been a pop tart and pieces of a cheese omelet. -She was aware Resident #6 used utensils to eat his food at the breakfast meal service on 08/27/25 because she assisted him with his meal at the dining table. -She was not aware Resident #6 should not have been provided with utensils to eat his food at meals. -She relied on dietary staff to provide meals for residents at meal services because she had	D 310		

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D 310	Continued From page 5 started recently and was not aware of all the residents' diets orders. Interview with the Resident Care Coordinator on 08/27/25 at 8:50am revealed: -Resident #6 was ordered a FF diet due to Resident #6's dementia. -Dietary staff were responsible for plating the food at meals and the PCAs were responsible for serving food to the residents. -She did not know Resident #6 was not served according to his FF diet at the lunch meal service on 08/26/25 and at the breakfast meal service on 08/27/25 with use of utensils. -The DM and the cook were responsible for ensuring residents' diets were served as ordered. Interview with the Administrator on 08/27/25 at 9:00am revealed: -She did not know Resident #6 was not served according to his FF diet at the lunch meal service on 08/26/25 and at the breakfast meal service on 08/27/25 with using utensils at each meal. -The DM and the cook were responsible for serving diets as ordered to the residents. Attempted telephone interview with Resident #6's responsible party on 08/27/25 at 9:30am was unsuccessful. Based on observations and interviews it was determined the Special Care Unit Coordinator (SCUC) was not interviewable due to being out of the facility.	D 310		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 6 (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 ensure medications were administered as ordered for 1 of 5 residents (#1) sampled residents including errors regarding sliding scale insulin (SSI) Novolog. The findings are: Review of Resident #1's current FL2 dated 02/18/25 revealed: -Diagnoses included type paraplegia, 2 diabetes mellitus, arthrodesis status, and other specified diseases of the spinal cord. -There was an order to check fingerstick (FSBS) before meals. Review of Resident #1's record revealed Resident #1's signed physician's orders dated 05/12/25 for Novolog check FSBS three times a day before each meal and inject per sliding scale insulin (SSI) parameters: FSBS 0-124= 0 units, 125-150= 6 units, 151-200= 8 units, 201-250= 10 units, 251-300= 12 units, 301-400=14 units, and greater than 400= 16 units. Review of Resident #1's June 2025 electronic medication administration record (eMAR) from 06/01/25 through 06/30/25 revealed: -There was an entry to check FSBS three times a day before each meal scheduled at 7:30am,	D 358		

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D 358	Continued From page 7 11:30am, and 4:30pm. -There was an entry for Novolog flex pen 100 units/ml inject per SSI parameters: FSBS 0-124= 0 units, 125-150= 6 units, 151-200= 8 units, 201-250= 10 units, 251-300= 12 units, 301-400=14 units, and greater than 400= 16 units scheduled for 7:30am, 11:30am, and 4:30pm. -FSBS's ranged from 61 to 274. -The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS values, and a space for documenting the amount of Novolog administered. -Examples of Resident #1's FSBS values documented on the June 2025 eMAR but documentation for the different amount of Novolog administered were as follows: -On 06/02/25 at 4:30pm, FSBS was 130 and 6 units of Novolog should have been administered but 0 units of Novolog was documented as administered on the eMAR. -On 06/21/25 at 4:30pm, FSBS was 166 and 8 units of Novolog should have been administered but 0 units of Novolog was documented as administered on the eMAR. -There was no additional notes for the amount of Novolog not administered for 06/02/25 and 06/21/25. Review of Resident #1's July 2025 eMAR from 07/01/25 through 07/31/25 revealed: -There was an entry to check FSBS three times a day before each meal scheduled at 7:30am, 11:30am, and 4:30pm. -There was an entry for Novolog flex pen 100 units/ml inject per SSI parameters: FSBS 0-124= 0 units, 125-150= 6 units, 151-200= 8 units, 201-250= 10 units, 251-300= 12 units, 301-400=14 units, and greater than 400= 16 units scheduled for 7:30am, 11:30am, and 4:30pm.	D 358		

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D 358	Continued From page 8 -FSBS's ranged from 79 to 371. -The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS values, and a space for documenting the amount of Novolog administered. -Examples of Resident #1's FSBS values documented on the July 2025 eMAR but documentation for the different amount of Novolog administered were as follows: -On 07/01/25 at 4:30pm, FSBS was 156 and 8 units of Novolog should have been administered but 0 units of Novolog was documented as administered on the eMAR. -On 07/05/25 at 11:30am, FSBS was 177 and 8 units of Novolog should have been administered but 0 units of Novolog was documented as administered on the eMAR. -On 07/11/25 at 7:30am, FSBS was 133 and 6 units of Novolog should have been administered but 0 units of Novolog was documented as administered on the eMAR. -On 07/14/25 at 11:30am, FSBS was 147 and 6 units of Novolog should have been administered but 0 units of Novolog was documented as administered on the eMAR. -On 07/25/25 at 4:30pm, FSBS was 146 and 6 units of Novolog should have been administered but 0 units of Novolog was documented as administered on the eMAR. -On 07/28/25 at 11:30am, FSBS was 147 and 6 units of Novolog should have been administered but 0 units of Novolog was documented as administered on the eMAR. -There was no additional notes for the amount of Novolog not administered for 07/01/05, 07/05/25, 07/11/25, 07/14/25, 07/25/25, and 07/28/25. Review of Resident #1's August 2025 eMAR from 08/01/25 through 08/25/25 revealed:	D 358		

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D 358	Continued From page 9 -There was an entry to check FSBS three times a day before each meal scheduled at 7:30am, 11:30am, and 4:30pm. -There was an entry for Novolog flex pen 100 units/ml inject per SSI parameters: FSBS 0-124= 0 units, 125-150= 6 units, 151-200= 8 units, 201-250= 10 units, 251-300= 12 units, 301-400=14 units, and greater than 400= 16 units scheduled for 7:30am, 11:30am, and 4:30pm. -FSBS's ranged from 114 to 596. -The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS value, and a space for documenting the amount of Novolog administered. -Examples of Resident #1's FSBS values documented on the August 2025 eMAR but documentation for the different amount of Novolog administered were as follows: -On 08/02/25 at 7:30am, FSBS was 179 and 8 units of Novolog should have been administered but 0 units of Novolog was documented as administered on the eMAR. -On 08/02/25 at 11:30am, FSBS was 164 and 8 units of Novolog should have been administered but 0 units of Novolog was documented as administered on the eMAR. -On 08/11/25 at 7:30am, FSBS was 132 and 6 units of Novolog should have been administered but 0 units of Novolog was documented as administered on the eMAR. -On 08/11/25 at 4:30pm, FSBS was 145 and 6 units of Novolog should have been administered but 8 units of Novolog was documented as administered on the eMAR. -On 08/17/25 at 7:30am, FSBS was 143 and 6 units of Novolog should have been administered but 0 units of Novolog was documented as administered on the eMAR. -On 08/17/25 at 11:30am, FSBS was 131 and 6	D 358	D358 All Med Tech will be inserviced on sliding scale insulin documenation and refusal documentation. by 10-20-2025 DSC and RCC will monitor sliding scale insulin documentation 3 times a week x 4 weeks then monthly and as needed. To ensure correct dose and correct documentation of sliding scale insulin.	

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D 358	Continued From page 10 units of Novolog should have been administered but 0 units of Novolog was documented as administered on the eMAR. -There was no additional notes for the amount of Novolog administered for 08/11/25 and for the amount of Novolog not administered on 08/02/25, 08/11/25, and 08/17/25. Observation of medications available for administration for Resident #1 on 08/27/25 at 2:50pm revealed Novolog insulin was available for administration and was dispensed on 5/12/25. Interview with Resident #1 on 08/27/25 at 2:40pm revealed: -They completed her FSBS frequently every day and sometimes her insulin changes. -She was not sure how much insulin she received but she usually received insulin every day. -She denied any current issues with low blood sugar levels or having experienced symptoms related to headaches or dizziness. Interview with a medication aide (MA) on 08/27/25 at 2:55pm revealed: -She was aware of Resident #1's Novolog insulin parameters and about her FSBS 3 times a day. -She could not say why Novolog insulin amounts were documented differently from the SSI parameter required amounts ordered by Resident #1's endocrinologist. -The Resident Care Coordinator (RCC) and the Special Care Unit Coordinator (SCUC) were responsible for reviewing the eMAR audits but she had not been informed of any medication errors. Interview with another MA on 08/27/25 at 3:10pm revealed: -Resident #1 had Novolog insulin and FSBS 3	D 358		

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D 358	Continued From page 11 times a day. -She was not aware Resident #1's Novolog insulin amounts were documented differently from the SSI parameter required amounts ordered by Resident #1's endocrinologist. Interview with the RCC on 08/27/25 at 4:05pm revealed: -Resident #1 had an order for FSBS 3 times a day. -She expected MAs to administer Resident #1's Novolog insulin as ordered. -She and the SCUC were responsible for auditing the eMARs for exceptions. -She audited eMARs weekly but did not see that Resident #1's Novolog insulin amounts were administered differently than the SSI parameter requirements ordered by Resident #1's endocrinologist. Interview with the Administrator on 08/27/25 at 4:20pm revealed: -She was not aware Resident #1's Novolog insulin amounts were administered differently than the SSI parameter requirements until the prior evening (08/26/25) and she had addressed the errors with the MAs. -The RCC and the SCUC would be responsible for auditing the residents' eMARs monthly. -The RCC and the SCUC would be responsible to ensure medication errors were addressed with MAs and corrected. -She expected MAs to administer as ordered by the provider. Attempted telephone interviews with Resident #1's endocrinologist on 08/27/25 at 10:15am and 2:15pm were unsuccessful. Based on observations and interviews it was	D 358		

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D 358	Continued From page 12 determined the SCUC was not interviewable due to being out of the facility.	D 358		