STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011338	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE OF ASHEVILLE	3199 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 10/28/25 - 10/29/25.	D 000		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to have a matching therapeutic diet menu for the guidance of food service staff for 1 of 2 sampled residents (#7) who had a physician ordered mechanical soft chopped diet. The findings are: Review of Resident #7's FL2 dated 02/24/25 revealed diagnoses included hypertension, hypothyroidism, and shortness of breath. Review of Resident #7's physician orders dated 02/24/25 revealed a physician ordered mechanical soft chopped diet. Review of the therapeutic diet list posted in the kitchen revealed Resident #7 received a	D 296		

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D 296	Continued From page 1 mechanical soft chopped diet. Observation of the kitchen on 10/28/25 at 10:07am revealed there was no therapeutic diet menu available for a mechanical soft chopped diet. Interview with the Dietary Director on 10/28/25 at 10:21am revealed: -He did not have a therapeutic diet menu for the physician ordered mechanical soft chopped diet for Resident #7. -He was not aware this needed to be available for guidance for food service staff. Interview with the Executive Director on 10/28/25 at 4:16pm revealed: -There should be a therapeutic diet menu for each variation of diet the facility provided for the residents. -The Dietary Director was responsible for having the therapeutic diet menu posted for guidance of food service staff. -The corporate dietician ensured the therapeutic diet menu was available for every physician ordered diet on the corporate website. -She was not aware the Dietary Director had not made the therapeutic diet menus available for the guidance of food service staff.	D 296		
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		

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D 306	Continued From page 2	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 20 of 24 assisted living (AL) residents at a lunch meal, 20 of 21 AL residents at a breakfast meal, and 14 of 16 residents in the special care unit (SCU) at a lunch meal in addition to other beverages.

The findings are:

1. Observation of the lunch meal service in the AL dining room on 10/28/25 between 11:57am and 12:21pm revealed:
-There were 24 residents present for the lunch meal service.
-There were 4 residents with water.
-The other 20 residents had various drinks including coffee, tea, and various juices.

Interviews with several residents in the AL dining room on 10/28/25 between 12:15pm and 12:21pm revealed:
-They only got water at mealtimes if they asked for it.
-Water was not offered at every meal.
-If water was available, they would drink it.
-One of the residents would prefer water to be available at mealtimes.

Observation of the breakfast meal service in the AL dining room on 10/98/25 between 8:06am and 8:23am revealed:
-There were 20 residents present for the

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D 306	Continued From page 3	D 306		

breakfast meal service.
-There was 1 resident with water.
-The other 19 residents had various drinks including coffee, milk, and various juices.

Interview with several residents in the AL dining room on 10/29/25 between 8:16am and 8:23am revealed:
-Staff had not offered them water at breakfast.
-If water was available, they would drink it.
-Water was not offered at any meal because they had water in their apartments.
-One resident drank water when taking medications and that was enough for her.

Refer to the interview with the cook on 10/29/25 at 8:30am.

Refer to the interview with the Dietary Director on 10/29/25 at 8:36am.

Refer to the interview with the Executive Director (ED) on 10/29/25 at 2:31pm.

2. Observation of the lunch meal service in the SCU dining room on 10/28/25 between 12:03pm and 12:20pm revealed:
-There were 14 residents present for the lunch meal service.
-The medication aide (MA) poured nutritional supplements into 8 oz cups and served them to 5 residents and iced tea in 8 oz cups was served to the additional 9 residents.
-Water was not served to the residents.

Interview with the MA on 10/29/25 at 8:03am revealed the residents were not always served water because it was overwhelming for residents in the SCU to have too many options placed on the table in front of them.

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D 306	Continued From page 4 Interview with the Special Care Coordinator (SCC) on 10/29/25 at 8:35am revealed: -All the residents in the SCU should be served water at every meal. -There were enough cups in the SCU dining room to ensure the residents would have water. -All the staff were aware that water should be served. -She did not know why the water was not served. Refer to the interview with the cook on 10/29/25 at 8:30am. Refer to the interview with the Dietary Director on 10/29/25 at 8:36am. Refer to the interview with the Executive Director (ED) on 10/29/25 at 2:31pm. _____ Interview with the cook on 10/29/25 at 8:30am revealed: -All residents in the AL and SCU dining rooms were supposed to be offered water at every meal. -He was not aware the residents were not receiving water in addition to other beverages at every meal. Interview with the Dietary Director on 10/29/25 at 8:36am revealed: -Many residents in AL would not drink water at mealtimes since they could get water at the hydration stations throughout the facility. -Water was always available for the residents if they asked for it at mealtimes. Interview with the ED on 10/29/25 at 2:31pm revealed: -She did not know that residents were not served water in the SCU and the AL dining rooms.	D 306		

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D 306	Continued From page 5 -There were enough glasses to ensure all residents were served water. -She expected staff to serve water to the residents.	D 306		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure implementation of an activities program that promoted active involvement by residents in the special care unit (SCU). The findings are: Observation of the daily calendar event listing for 10/29/25 in the SCU revealed: -There was documentation of "Sunrise Singing" scheduled for 10:00am. -There was documentation of "armchair exercise" scheduled for 10:45am. -There was documentation of "Fall decorating" scheduled for 11:00am. Observation in the SCU on 10/29/25 at 10:10am	D 315		

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D 315	Continued From page 6	D 315		

revealed:
-There were 9 residents sitting in the common living area.
-There was a personal care aide (PCA) sitting in the common living area but was not engaging the residents in activities.
-The television was on.

Observation in the SCU on 10/29/25 at 10:25am revealed:
-There were 9 residents sitting in the common living area.
-There was a personal care aide (PCA) sitting in the common living area but was not engaging the residents in activities.
-The television was on.

Observation in the SCU on 10/29/25 at 10:50am revealed:
-There were 9 residents sitting in the common living area.
-There was a medication aide (MA) at the nurse's station with a clear view of the common living area.
-The MA was not engaging the residents in activities.
-The television was on.

Interview with the MA on 10/29/25 at 10:56am revealed:
-They normally had an activity person who conducted activities for the SCU residents.
-The activity person was currently on vacation.
-It had been a very busy morning for all staff, and they just had not started on activities yet.

Observation in the SCU on 10/29/25 at 11:03am revealed:
-There were 9 residents sitting in the common living area.

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D 315	Continued From page 7 -There was a personal care aide (PCA) sitting in the common living area but was not engaging the residents in activities. -The television was on. Interview with the PCA on 10/29/25 at 11:04am revealed: -They had an activity staff person that conducted activities in the SCU. -The activity staff person was not at work on 10/29/25. -It was the responsibility of the other staff working on the SCU to provide activities for the residents if the activity staff person was not available. -She had been very busy this morning and had not had time to conduct activities for the residents. Interview with the Executive Director on 10/29/25 at 2:30pm revealed: -Residents in the SCU had activities 7 days a week. -The facility had an Enrichment Director who was responsible for SCU activities. -The Enrichment Director was not working on 10/29/25 so the SCU staff was responsible for conducting the activities. -The SCU staff were aware activities are to be provided for the residents in the absence of the Enrichment Director or if the Memory Care Director was absent or busy. -The SCU staff did not conduct the planned activities for the SCU the morning of 10/29/25.	D 315		