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
	HAL034108	A. BUILDING: _____ B. WING _____	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/RECORD VILLA	250 PITT STREET 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 survey on 10/21/25.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled residents (#1 #2) had completed the two-step tuberculosis (TB) testing in compliance with the control measures adopted by the Commission for Public Health. The findings are: 1. Review of Resident #1's current FL2 dated 05/02/25 revealed diagnoses included Crohn's disease, hematuria, congestive obstructive pulmonary disease, nephritis, Alzheimer's and schizoaffective disorder, bipolar type 2 insomnia, anxiety, vitamin D deficiency, hyperlipidemia, diabetes type 2, and neuropathy.	D 234	Moving forward the office management will verify all TB tests administerd with all documentation. with all documentation. Name, date, time and result. Admin. will check for accuracy monthly. 12-1-25 #1 Resident had a quantiferon TB on 10-21-20 with a negative result.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheila B. Shuler — TITLE: Administrator — (X6) DATE: 12-1-25

" Reviewed and Acknowledged " 12/05/2025 CPP