PRINTED: 11/04/2025
FORM APPROVED

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
	HAL006007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 and the Avery County Department of Social Services conducted an annual survey and complaint investigation on 10/14/25-10/15/25. The complaint investigation was initiated by the Avery County Department of Social Services on 10/13/25.	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 soley as a matter of compliance with state laws.	
D 108	10A NCAC 13F .0311 (b)(2) Other Requirements 10A NCAC 13F .0311 Other Requirements (b) The following shall apply to heaters and cooking appliances: (2) unvented fuel burning room heaters and portable electric heaters are prohibited; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to prohibit the use of a portable electric heater used one staff office. The findings are: Observation of a staff office in the facility on 10/14/25 at 10:26am revealed: -There was a portable electric heater under a desk. -The heater was plugged into a power surge protector that was plugged into an electrical outlet. Interview with the Special Care Coordinator (SCC) on 10/14/25 at 10:57am revealed. -She brought the portable electric heater to her office from home and she used it because she was cold. -She did not know the heater was not allowed in the facility because no one informed her.	D 108	Facility Management will be in-serviced on the cited rule area .0311 (b)(2), to ensure compliance. The Executive Director and/or designee will conduct walk-throughs no less than once weekly for 60 days to ensure that no heaters or other prohibited appliances are present in the facility.	12/1/25

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Timothy Jenkins — TITLE: Executive Director — (X6) DATE: 11/25/25

STATE FORM 6899 10A311 If continuation sheet 1 of 15

Reviewed & Acknowledged 12/5/25 Jillie Brooks

PRINTED: 11/04/2025
FORM APPROVED

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
	HAL006007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 108	Continued From page 1 Telephone interview with the Maintenance Director on 10/15/25 at 1:23pm revealed: -He did not know the portable electric heater was in an office. -He heard that portable electric heaters were not allowed in the facility but did not remember who told him. -He only went into staff offices when something needed to be repaired. Interview with the Administrator on 10/14/25 at 11:00am revealed: -He did not know the portable electric heater was in the office. -All staff were informed that those type of heaters were not allowed in the facility.	D 108		
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, interviews, and record reviews, the facility failed to have a matching therapeutic diet menu for guidance of food service staff for 1 of 4 sampled residents (Resident #6) who had orders for a mechanical	D 296	Executive Director and Dietary Manager will be inserviced on the cited rule area, .0904 (c)(7). The Executive Director and Dietary Manager will be in-serviced on locating and accessing the facility's current menus, including all diet extensions. A designated and clearly identified location will be established for storing these menus so they are consistently available for staff reference. Facility dietary staff will be in-serviced on how and where to locate the facility's current menus, including all diet extensions, to ensure they are consistently referenced when preparing resident meals. The Executive Director and/or designee will conduct routine checks no less than once weekly for 60 days to ensure that the facility menus, including all diet extensions are consistently maintained in the kitchen and readily accessible for staff reference.	12/1/25

PRINTED: 11/04/2025
FORM APPROVED

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
	HAL006007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 296	Continued From page 2 soft diet with chopped meat. The findings are: Review of Resident #6's current FL2 dated 07/08/25 revealed: -Diagnoses included dementia and hypoxic respiratory failure. -There was an order for a mechanical soft, no added salt, double portion, and chopped meat diet. Observation in the kitchen on 10/14/25 at 10:05am revealed: -There was a therapeutic diet order list posted on the refrigerator. -There was a weekly regular diet menu posted on a board. -There was no therapeutic diet menu for food service staff guidance posted. Observation of the lunch meal service for Resident #6 on 10/14/25 from 11:49am to 12:38pm revealed: -Resident #6 was served a bologna sandwich cut into fourths, baked beans and pineapple chunks. -The bologna was approximately a quarter inch thick and approximately 4-5 inches wide. Interview with the cook on 10/14/25 at 11:58am and 12:20pm revealed: -There were multiple residents who had orders for therapeutic diets including pureed, mechanical soft, chopped meat, and ground meats. -There was no therapeutic diet menu available for guidance of kitchen staff to prepare therapeutic diets. -She had worked as a cook at the facility since December 2024 and had never seen a therapeutic diet menu available.	D 296		

PRINTED: 11/04/2025
FORM APPROVED

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
	HAL006007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 296	Continued From page 3 -She was never formally trained as a cook but was verbally told by the dietary manager how prepare pureed, mechanical soft, ground meat, and chopped meat diets. -Resident #6 requested a bologna sandwich as an alternative to the chicken casserole being served for lunch. -She cut Resident #6's bologna sandwich into fourths because Resident #6 often requested a bologna sandwich as an alternative and liked it cut into handheld pieces. -She was previously told by the dietary manager that cutting a sandwich into fourths was considered chopped meat. Interview with the Dietary Manager on 10/15/25 at 2:50pm revealed: -She had worked at the facility for about a year and a half. -She did not print the therapeutic diet menus for the kitchen staff because she "just knew" how to prepare all the therapeutic diets ordered and verbally told the cook and cook's assistant how to prepare the meals. -She did not formally train the cook how to prepare therapeutic diets because she was temporarily out of work when the cook was hired. -Resident #6 previously got choked a couple of times while eating so he was ordered a mechanical soft chopped meat diet. -A bologna sandwich cut into fourths was not considered chopped meat. Interview with the Administrator on 10/14/25 at 4:13pm revealed: -The facility had therapeutic diet menus available on the computer system. -The Dietary Manager was responsible for printing out the daily menu and posting it in the kitchen for food service staff to reference when	D 296		

PRINTED: 11/04/2025
FORM APPROVED

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
	HAL006007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 296	Continued From page 4 preparing therapeutic diets. -He was not aware a therapeutic diet menu was not posted in the kitchen. -The Dietary Manager was responsible for training the staff in the kitchen on how to prepare meals including therapeutic diets. -He did not know why the cook was not trained to reference the therapeutic diet menu when preparing meals or why the therapeutic menus were not being printed and posted. -He expected the Dietary Manager to properly train kitchen staff and therapeutic diet menus be used as guidance for food service staff to prepare therapeutic diets as ordered.	D 296		
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: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure a therapeutic diet was served as ordered for 3 of 5 sampled residents (#1, #4, and #6) who had orders for pureed and nectar thickened liquids (#1), no added table salt, mechanical soft and chopped meat diet (#6), and a nutritional supplement shake three times daily with meals (#4).	D 310	Executive Director and Dietary Manager will be in-serviced on the cited rule area, .0904 (e)(4). Dietary staff will be re-educated on the proper preparation and service of all therapeutic diets, including the correct preparation of thickened liquids as ordered by residents' physicians. The Executive Director and/or Dietary Manager will monitor no fewer than one meal per week for 60 days to ensure that all residents are receiving the physician-ordered therapeutic diets, including thickened liquids when applicable.	11/28/25

PRINTED: 11/04/2025
FORM APPROVED

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
	HAL066007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 310	Continued From page 5 The findings are: 1. Review of Resident #1's current FL2 dated 10/10/25 revealed: -Diagnoses included Alzheimer's disease, dementia, and traumatic brain injury. -There was an order for a pureed diet with nectar thickened liquids. Review of Resident #1's FL2 dated 04/24/25 revealed: -Diagnoses included Alzheimer's disease, dementia, and traumatic brain injury. -There was an order for a pureed diet with nectar thickened liquids. Review of Resident #1's Resident Register revealed an admission date of 08/08/16. Review of Resident #1's Care Plan dated 03/17/25 revealed: -Resident #1 had dietary restrictions documented as a pureed diet with nectar thickened liquids. -He required limited assistance from staff with eating. Observation in the kitchen on 10/14/25 at 10:05am revealed: -There was a therapeutic diet order list posted on the refrigerator. -There was a weekly regular diet menu posted on a board. -There was no therapeutic diet menu for food service staff guidance posted. Observation of the lunch meal service for Resident #1 on 10/14/25 from 11:49am to 12:38pm revealed: -Resident #1 was served pureed chicken casserole, pureed baked beans, pureed	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL006007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 310	Continued From page 6	D 310		

pineapple, nectar thickened water, nectar thickened tea, and coffee.
-A personal care aide (PCA) held the coffee cup to Resident #1's mouth and Resident #1 drank about 4 ounces from the cup.
-The coffee did not appear to be thickened to nectar consistency.
-The PCA was asked to refrain from letting Resident #1 drink more coffee until she made sure it was thickened to nectar consistency.
-The PCA took Resident #1's coffee cup to the kitchen and returned to the table where Resident #1 was sitting.
-The PCA picked up a nutritional supplement shake and poured some into the coffee cup adding approximately 4 ounces liquid to the cup, stirred it with a spoon, and offered Resident #1 another drink of the coffee mixed with the nutritional supplement shake.
-Resident #1 coughed and his face turned red throughout the entire meal service while eating and drinking.

Interview with a PCA on 10/14/25 at 12:05pm revealed:
-The kitchen staff were responsible for thickening liquids for Resident #1.
-She did not think Resident #1's coffee looked as thick as the tea or water served to Resident #1.
-She asked the cook's assistant if Resident #1's coffee was thickened and was told a half a packet of coffee thickener was used for the coffee cup of water.
-The cook's assistant told her he forgot to stir the coffee drink mix after he mixed it with the water until the thickener dissolved.
-She added a chocolate flavored nutritional supplement shake to Resident #1's coffee to give it some flavor.
-She did not add any additional thickener to the

PRINTED: 11/04/2025
FORM APPROVED
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
	HAL006007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 310	Continued From page 7	D 310		

nutritional supplement shake mixed with the coffee before offering it to Resident #1.
-She did not think supplement shakes had to be thickened for a resident with orders for nectar thickened liquids because they seemed like they were a thicker consistency.
-Resident #1 always coughed and turned red in the face when he was eating and drinking.

Observation of the thickened coffee drink mix nectar consistency packet on 10/14/25 at 12:12pm revealed:
-The cook's assistant provided an opened and partially used packet identified as the packet used to thicken Resident #1's water in the coffee cup.
-A serving size was one packet.
-The directions on the back said to pour contents of packet into a cup, add 6 ounces of hot water, and stir until powder dissolves.
-There was a note to mix in sugar, sweetener, or up to 3/8 fluid ounces of creamer as desired.

Interview with a medication aide (MA), who was assisting residents in the dining room, on 10/14/25 at 12:23pm revealed:
-She did not know if nutritional supplements were supposed to be thickened when a resident had orders for nectar thickened liquids.
-Staff always served Resident #1's nutritional supplements from the original container without adding thickeners.
-The kitchen staff were responsible for preparing Resident #1's drinks and putting them on the table for Resident #1.

Interview with the cook's assistant on 10/14/25 at 12:35pm revealed:
-He was told by the Kitchen Manager to use a half a packet of thickened coffee drink mix to a coffee cup of hot water to thicken Resident #1's coffee

PRINTED: 11/04/2025
FORM APPROVED

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
	HAL000007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 310	Continued From page 8 to nectar consistency. -He did not read the directions on the back of the packet. -He used half of a packet of thickened coffee drink mix in a coffee cup filled with hot water to serve to Resident #1 for the lunch meal service on 10/14/25. Interview with the Kitchen Manager on 10/15/25 at 8:50am revealed: -The facility purchased pre-thickened, nectar consistency juice, water, and tea. -The only drink served to residents with an order for nectar consistency that required to be thickened was coffee. -She was responsible for training kitchen staff how to thicken liquids. -She never read the instructions on the back of the thickened coffee drink mix and she always used a half packet of the thickened coffee drink mix to a coffee cup of hot water because that was how she was taught to thicken liquids by the former Kitchen Manager. -The coffee cup held 8 ounces water. Telephone interview with Resident #1's hospice registered nurse (RN)/Clinical Manager on 10/15/25 at 1:15pm revealed: -Resident #1 was ordered nectar thickened liquids because he could not swallow thin liquids. -Resident #1 had dementia and a traumatic brain injury which placed him at a high risk of aspirating (breathing in liquid or foods into the lungs). -If Resident #1 was served liquids that were not nectar thickened consistency, he could aspirate, develop pneumonia, and require hospitalization. Interview with the Administrator on 10/14/25 at 4:13pm revealed: -The Dietary Manager was responsible for	D 310		

PRINTED: 11/04/2025
FORM APPROVED

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
	HAL006007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 310	Continued From page 9 keeping a list of therapeutic diet orders posted in the kitchen. -The Dietary Manager was responsible for training staff how to prepare therapeutic diets. -The cook or cook's assistant gave all the residents their drinks and nutritional supplement shake in the dining room and were responsible for thickening liquids to the ordered consistency. -The cook or cook's assistant were responsible for reading the directions on the back of the coffee thickened powder package and mixing the coffee drink to the ordered consistency. -He expected staff to serve therapeutic diets, nutritional shakes, and liquids as ordered. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. 2. Review of Resident #6's current FL2 dated 07/08/25 revealed: -Diagnoses included dementia and hypoxic respiratory failure. -There was a diet order for no added table salt, mechanical soft and chopped meat. Observation in the kitchen on 10/14/25 at 10:05am revealed: -There was a therapeutic diet order list posted on the refrigerator. -There was a weekly regular diet menu posted on a board. -There was no therapeutic diet menu for food service staff guidance posted. Observation of the lunch meal service for Resident #6 on 10/14/25 from 11:49am to 12:30pm revealed: -Resident #6 was served a bologna sandwich cut into fourths, baked beans and pineapple chunks.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL006007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 310	Continued From page 10 The Surveyor informed the Cook Resident #6 was served a bologna sandwich cut into fourths and was not chopped. -The bologna slice was approximately a quarter inch thick and approximately four inches wide. -Resident finished his meal without difficulty. Interviews with the Cook on 10/14/25 at 11:58am and 12:20pm revealed: -The lunch to be served on 10/14/25 was chicken casserole, baked beans and pineapple chunks. -Resident #6 requested a bologna sandwich as an alternative to chicken casserole. -Resident #6 requested the sandwich to be served in quarters and not chopped. -She cut resident #6 bologna sandwich into fourths because Resident #6 often requested a bologna sandwich as an alternative and liked it cut into handheld pieces. -The Dietary Manager (DM) informed her that cutting a sandwich into fourths was chopped meat. -She had been the cook since December 2024 but was not formally trained or taught how to prepare therapeutic diets. -The DM directed her on how the facility wanted the food prepared. Interview with the DM on 10/15/25 at 8:45am revealed: -Resident #6 was supposed to be served a mechanical soft diet with chopped meat. -She was responsible for training dietary staff on preparing therapeutic diets. -Resident #6 previously choked a couple of times while eating so he was ordered a mechanical soft chopped meat diet. -A sandwich cut into fourths was not considered to be a mechanical soft and chopped diet. -Resident #6 requested a bologna sandwich as	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL006007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 310	Continued From page 11	D 310		

an alternative to chicken casserole being served for lunch.
-Resident #6 often requested his sandwich not chopped.

Interview with the Administrator on 10/14/25 at 4:13pm revealed:
-The DM was responsible for training kitchen staff.
-The DM was responsible for ensuring the residents were served the correct diet.
-He expected staff to serve therapeutic diets as ordered.

Attempted interview with Resident #6's Primary Care Provider (PCP) on 10/14/25 at 4:44pm was unsuccessful.

3. Review of Resident #4's current FL2 dated 09/26/25 revealed diagnoses included dementia and generalized weakness.

Review of Resident #4's physician's order dated 10/10/25 revealed an order for a regular diet with a fortified nutritional supplement shake with vitamins and minerals designed to supplement dietary calories and protein three times daily with meals.

Review of the resident diet list posted in the kitchen on the refrigerator on 10/14/25 at 10:03am revealed Resident #4 was listed as a regular diet with nutritional shakes to be served at 7:00am, 12:00pm, and 5:00pm.

Review of a handwritten list posted on the refrigerator of residents to receive nutritional shakes on 10/14/25 at 10:03am revealed:
-There were 25 resident names handwritten under a list of nutritional shakes.

PRINTED: 11/04/2025
FORM APPROVED

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
	HAL006007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 310	Continued From page 12	D 310		

-Resident #4's name was not on the handwritten list to receive nutritional shakes.

Observation of the lunch meal service for Resident #4 on 10/14/25 from 11:49am to 12:38pm revealed:
-Resident #4 was served a glass of tea and water, chicken casserole, baked beans, biscuit, and pineapple chunks.
-There was no nutritional shake supplement given to Resident #4.

Interview with the cook on 10/14/25 at 12:30pm revealed:
-Resident #4 was not on the handwritten list made by the Dietary Manager to receive nutritional shakes.
-The cook's assistant referred to the handwritten list to give the nutritional shakes out to residents.
-The cook's assistant "just missed" giving Resident #4 a nutritional shake because the handwritten list was incorrect.

Interview with the cook's assistant on 10/14/25 at 12:35pm revealed:
-He normally gave Resident #4 a nutritional shake three times a day.
-He did not give Resident #4 a nutritional shake on 10/14/25 at 12:00pm because two staff were sitting at the table before the lunch meal where Resident #4 sat.

Telephone interview with Resident #4's primary care provider (PCP) on 10/15/25 at 9:30am revealed:
-She ordered nutritional shakes three times daily with meals for Resident #4 because Resident #4 had an overall decline in health and was not eating as much.
-Resident #4 had some weight loss after a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL006007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 310	Continued From page 13 previous hospitalization. -If Resident #4 did not receive the nutritional shake supplements as ordered she could experience malnutrition, osteoporosis, weight loss, and failure to thrive. Interview with the Administrator on 10/14/25 at 4:13pm revealed: -The facility did not have a policy for therapeutic diets or nutritional shakes. -The residents' diets were typed out on a list including the nutritional supplements by the Dietary Manager and posted in the kitchen for staff. -He knew there was a handwritten list posted in the kitchen that combined all the resident names in one column who had orders to receive nutritional shakes. -He expected the cook or cook's assistant to give Resident #4 a nutritional shake if it was ordered. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. The facility failed to ensure nectar thickened liquids were served as ordered to Resident #1, who was observed coughing and turning red in the face during the lunch meal service on 10/14/25. Resident #1 was at risk of aspirating which could cause pneumonia and/or hospitalization. This failure was detrimental to the health, safety, and welfare of Resident #1 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/14/25 for this violation. THE CORRECTION DATE FOR THIS TYPE B	D 310		

PRINTED: 11/04/2025
FORM APPROVED

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
	HAL006007	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRANBERRY HOUSE	6255 US HIGHWAY 19 EAST NEWLAND, NC 28657

(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 310	Continued From page 14 VIOLATION SHALL NOT EXCEED NOVEMBER 28, 2025.	D 310		