D 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey on 11/18/2025-11/19/2025.	D 000		
D 067	IOA NCAC 13F .0305 Physical Environment IOA NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301 , the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observationst interviews, and record reviews, the facility failed to ensure 2 of 4 exit doors that were accessible to residents on the Special Care Unit (SCU) and 2 of 2 doors in the Locked Unit in the Assisted Living (AL) had a continuous sounding device that was responded to and deactivated by staff for the safety of the residents. The findings are:	D 067		

Spring Arbor of Greensboro

County: Guilford

License Number: HAL-041-088

It is Spring Arbor of Greensboro's policy and standard practice to comply with all North Carolina Adult Care rules and regulations.

IOA NCAC 13F .0305 (h)(4) Physical Environment

1 . How the Deficiency was Corrected

- Door alarms were installed on the exit doors to the Cottage Courtyards the same day of the survey 1 1 / 18/2025.upon door opening to alert team members.
- The alarms are audible throughout Cottage and activated.

2. Prevention of Recurrence

- The facility verifies that all resident-accessible exit doors in Memory Care have functioning and audible alarms.
- Memory Care team checks daily to ensure alarms are functioning appropriately.
- Memory Care team have been instructed to report any malfunctioning immediately to the Cottage Coordinator, Maintenance Director, or the Executive Director.

3. Monitoring to Ensure Ongoing Compliance

- The Maintenance Director or Designee will inspect door alarms monthly to ensure continued compliance. Results will be documented and corrective action will be implemented if deficiencies are noted.

Lina Lane, ED, RN 12-22-25

Regulation: IOA NCAC 13F .0306 Housekeeping and Furnishings

Deficiency:
A wound cleanser was left out on a bathroom sink in the Memory Care unit.

1 . Corrective Action

- Wound cleanser was removed from the bathroom sink and secured in a locked storage area on 1 1/18/2025.
- All Team Members were instructed that in Memory Care all wound cleansers, toiletries, cleaning products, etc. must be attended to during use and immediately secured after use.

2. Monitoring to prevent recurrence

- Routine rounds include checks for any unattended wound cleansers, cleaning products, toiletries, etc.
- SICs/MTs are responsible for ensuring that all products are not left in a residents' room. If found, the product is to be secured immediately. • Cottage Coordinator, RCC, and ED do random checks to ensure ongoing compliance.

1 OA NCAC 1 3F .0703 (b & c) Tuberculosis Test, Medical Exam & Immunization

Deficiency:

The FL-2 fora resident was not updated.

1 . Corrective Action

- Upon identification of the deficiency, the FL-2 was updated on 1 1/20/25, physician was contacted. FL-2 was updated and signed. The current FL2 was placed in the resident's chart.

2. Measures Implemented to prevent Recurrence

- RCC, ARCC, CCC 1, and CCC2 are ensuring the FL-2s are reviewed, updated, and signed by physician upon Move-In, with any change of condition, hospital admission, and annually.
- RCC keeps a tracker with all residents' FL-2s and reviews it weekly.

3. Staff Education

- ED reviewed FL-2 requirements and timelines with the Clinical Coordinators 1 1/20/2025.

4. Monitoring

- RCC, ARCC, CCC 1, and CCC2 will check tracker weekly and FL2 monthly to ensure compliance.

Regulation: I OANCAC 13F .0902(b) -Health Care

Deficiency:

Facility failed to obtain and document daily weights as ordered by the physician.

1 . Corrective Action

- On 1 1/20/2025 daily weight monitoring was initiated by RCC for the resident, she instructed the clinical team that weights must be obtained and documented per PCP orders.
- The ED reminded the coordinators of the importance of following PCP orders of daily weights, especially with a resident who has a diagnosis of CHF.

2. Monitoring measures to Prevent Recurrence

- RCC is reviewing weights daily and reviews with resident's PCP weekly (sooner if needed).
- Missed weights will be reported to PCP, addressed, and documented.

Regulation: IOA NCAC 13F .0904 (a)(2) Nutrition and Food Service

Deficiency

Facility failed to ensure food was protected from contamination related to foods stored in the walk-in cooler that were not labeled or dated, food with mold growth, and expired food, debris on floors, debris on the stove top, storage bins with debris in them, and a dirty grill.

1 . Corrective Action

- All unlabeled, undated, mold growth, and expired foods were discarded. Floors, stove tops, storage bins, lip on the front of the grill, were thoroughly cleaned and sanitized. Completion date was 1 1/20/2025.

2. Measures Put in Place to Prevent Recurrence

- The ED met with Food Service Director and reinforced food safety and sanitation process.
- FSD created cleaning logs for daily check offs on 1 1/25/2025.
- FSD met with his team and are ensuring the processes remain in place and are met on a daily basis.
- All foods are labeled and dated.
- Panel on the side of the stove was ordered. Panel was placed on 1 2/1 6/2025.
- Regional Vice President of Operations met with staff on 1 1 /20/2025 and reviewed state and Spring Arbor Food Services Regulations.
- FSD, FSSs, and ED do random checks to ensure compliance.

3. Monitoring:

- FSD and/or FSS will do daily checks to ensure compliance.
- ED will do random checks to ensure compliance.

Regulation: I OA NCAC 13F .0904 (b)(l) Nutrition and Food Services

Deficiency:

The facility failed to ensure mealtime table service included a place setting consisting of a knife, fork, and spoon in the Special Care Unit and the locked unit in AL.

1 . Corrective Action

' The ED met with the FSD on 1 1/20/2025 and reiterated that the SCU and locked unit must have a full place setting which is plate, spoon, fork, knife, napkin, and beverage.

- The Regional Vice President of Operations met with the Food Service Team and Director on 1 1 /20/2025, re-educated them on place settings for the Special Care Unit and the locked unit in AL.

2 Monitoring/Measures to Prevent Recurrence

- FSD and Food Service Supervisors ensure disposable dinner ware is not utilized and ensures daily that a full place setting is sent for each resident in the SCU and locked unit in AL.

Regulation: IOA NCAC 13F .0904(e)(3) Nutrition and Food Service

Deficiency:

The facility failed to maintain a current listing of residents with physician ordered therapeutic diets for guidance of food service.

1 . Corrective Action

- RCC and ARCC reviewed all residents' diet orders on 1 1 /20/25 and reviewed with PCP who then wrote new diet orders in accordance to Spring Arbors accepted diets.
- New diet orders were given to the FSD.
- Diet orders were updated in Yardi.

2 Measures to prevent recurrence

- RCC will give FSD and/or FSS a copy of all new diet orders/changes
- FSD will update his team and post correct diet order on bulletin board
- FSD and FSSs are monitoring and updating diet board weekly and as needed

3 Monitoring for compliance

- FSD and FSS will check diet board weekly and updating it with any new diet orders/changes.
- FSD and FSS will notify team of any changes to diet orders and of new residents' diets.

Regulation: IOA NCAC 13F .0904€(4) Nutrition and Food Service

Deficiency:

The facility failed to ensure that therapeutic diets were served as ordered for 2 out of 4 sampled residents.

1 . Corrective Action

- On 1 1 /20/25 we updated the diet book in the kitchen, including the diet board, and all medical records to ensure all matched according to PCP orders.
- ED met with RCC, ARCC, cccl , CCC2, and FSD and discussed importance of compliance with PCP diet orders and ensuring monitoring on a weekly and as needed basis.
- Regional Vice President of Operations met with FSD and dietary team on 1 1 /20/25 and discussed food services policy and procedures.

2. Measures implemented to prevent recurrence
    - Communication protocol is in place so that any changes in PCP orders or diet modifications are immediately implemented.

3. Monitoring
    - RCC will ensure FSD receives new diet orders.
    - FSD will review with the FS team any new diet orders and will update the diet board.
    - FSD and FSSs will ensure the new diet orders are implemented by monitoring meals that are being served.
    - FSD and FSSs will do random audits to ensure accuracy.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041088	A. BUILDING: _____ B. WNG _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF GREENSBORO	5125 MICHAUX ROAD GREENSBORO, NC 27410

(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)	COMPLETE DATE

Dina Lane ED, RN 12-22-25

Division Health Service Re ulation

D 067	Initial Comments The Adult Care Licensure Section conducted an Annual Survey on 11/18/2025-11/19/2025. IOA NCAC 13F .0305 Physical Environment IOA NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility, If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel, Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 4 exit doors that were accessible to residents on the Special Care Unit (SCU) and 2 of 2 doors in the Locked Unit in the Assisted Living (AL) had a continuous sounding device that was responded to and deactivated by staff for the safety of the residents. The findings are:	D 000 D 067		

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

of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	0<3) DATE SURVEY COMPLETED
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D 067	Continued From page I I. Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 100 beds; 28 beds were licensed for the SCU. Review of the facility's census on 11/18/25 revealed there were 13 residents residing in the SCU. Review of the facility's SCU disclosure statement revealed for the residents' safety the SCU was a secure area of the community with all points of entrance and exit were locked and alarm monitored including an enclosed courtyard Observations of the SCU on 11/18/25 at 8:35am and 3:31 pm revealed: -There were two doors in the resident living room that led to an outside courtyard, -The courtyard was enclosed with fence and a locked gate. -One of the doors was a side-by-side door on a long wall and a second door was a single door on a short length of wall. -There was only one doorknob on the side-by side doors; the door was not locked. -There was a chime when the door was opened, and it stopped when the door closed. -The side-by-side door was not locked from the outside. -The single door was not locked and did not alarm when the door was opened; there was a keypad next to the single door. -Once the single door closed it would not open from the outside. -Staff responded to the side-by-side door with the alarm when it was opened. -Staff did not respond to the single door without the alarm when it was opened.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0<2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 067	Continued From page 2 Telephone interview with the facility's contracted primary care provider (PCP) on 11/19/25 at 5:30pm revealed: -The purpose of the door alarms was to notify the staff when a resident opened a door. -Staff were usually in the living room area when she was at the facility. -There was a resident who was constantly exit seeking, but he was moved out of the facility. -She had no current concerns about any of the residents in the SCU and none of them were exit seeking. Interview with a personal care aide (PCA) on 11/19/25 at 9:35am revealed: -If a resident went outside in the courtyard the staff had to go outside with them. -There was one resident who liked to go outside and would open the door herself. -Both doors to the courtyard were not locked during the day but she thought they were locked at night. -She could hear the door alarm while in the living room area and in resident rooms. -She did not notice how long the door alarm stayed on when a door was opened. -The keypad was for the single door not the gate. -If staff went out the single door, they turned off the alarm at the keypad with a code, Interview with a medication aide (MA) on 11/18/25 at 3:40pm revealed: -The exit doors to the courtyard stayed unlocked. -There was a resident who liked to go outside to smoke but she moved to the Assisted Living (AL) side of the facility. -The staff would go into the courtyard with residents. -She thought the doors to the courtyard were locked at 11 :00pm every night.	D 067		

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D 067	Continued From page 3 -She and the other staff could hear the alarm on the one door anywhere in the SCIJ. -The door alarm stopped when the door closed. -She thought both doors had alarms. -The keypad beside the single door controlled the door alarm for that door. -All staff were trained to go to the door whenever they heard the door alarm Interview with a second MA on 11/19/25 at 9:15am revealed. -The doors to the courtyard had alarms on them but stopped when the doors closed. -If the doors were held open for a long time the alarms would stop. -There was a fence around the courtyard with a locked and alarmed gate. -The keypad was for the single door. -The doors were always open when she worked, she thought they were locked at night after she left. -Staff went outside with the residents when they were in the courtyard. -The doors were not locked from the outside. -She could not think of a resident that would try to go outside by themselves. Interview with the Maintenance Director on 11/19/25 at 9:00am revealed: -The doors in the SCU that exited from the living room into the courtyard both had alarms on them. -The door alarm on the single door had a dead battery yesterday, 11/18/25. -He replaced the battery in the door alarm, and the door alarm was working again. -The doors should not be locked from the outside and should open if entering the SCU from the courtyard. -The door alarms stopped when the doors closed.	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 067	Continued From page 4 Interview with the Special Care Unit Coordinator (SCC) on 11/18/25 at 3:45pm revealed: -The doors to the courtyard were unlocked and residents could go outside anytime. -Both doors had alarms on them and could be heard anywhere in the SCU. -The staff were required to respond to the door alarms and see who was going outside. -Staff were encouraged to go outside with the residents. -If the temperatures were too cold, like freezing, or snowing the staff would try to redirect the residents back inside. -The residents used the courtyard a lot; they also did activities in the courtyard. -The doors from the living room to the courtyard were never locked. -Both doors were unlocked from the outside and residents could reenter from the courtyard. -There were no residents who tried to go outside even though they were disoriented. Interview with the Executive Director (ED) on 11/19/25 at 8:05am revealed -There were two exit doors from the living room into the courtyard. -One of the doors from the living room to the counyard had an alarm that sounded when the door was opened. -The door alarm sounded like a chime. -The door alarm alerted staff that an exit door was opened. -Staff were supposed to check the door to see who opened it. -Residents were not to go in the yard alone, if the resident was outside the staff were supposed to stay with the resident. -The courtyard was surrounded by a fence with a locked and alarmed gate. -The keypad by the single door was for the gate,	D 067		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 067		D 067		
	Continued From page 5 not the door. -The second door was not alarmed and not locked because the residents did not use it. -There should always be one team member around the living room area so they could respond to the door alarm. -The doors were not locked from the outside and residents could reenter the SCU from the courtyard. -The doors to the courtyard were never locked; even overnight. -She did not know the doors needed to have a continuous sounding alarm on them. -She thought the current door alarm was all that was required. 2 Review of the facilitVs census on 11/18/25 revealed there were 10 residents residing in the locked unit in the AL. Review of the facility's floor plan map displayed in the hallway revealed 2 exit doors in the locked unit, 1 leading to a secure courtyard and 1 leading out to the parking lot. Observation of the residents who resided in the locked unit revealed that 9 of 10 residents were in wheelchairs. Observation of the locked unit exit doors on 11/18/25 at 8:23am revealed the two exit doors had a sounding device when they were opened and then stopped sounding when the door was closed. Interview with a personal care aide (PCA) on 11/18/25 at 8:40am revealed: -The staff members were responsible for going to the door to see why the door alarm was activated. -She was not aware of any residents attempting			

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D 067	Continued From page 6 to open the exit doors. Interview with the locked unit coordinator on 11/19/25 at 2:30pm revealed: -She was not aware that the alarms on the exit doors had to be continuous. -She had no incidents where a resident attempted to open the door since being her current position the last four months. -The PCAs and medication aides (MA) were responsible for checking the door and making sure all residents were accounted for when the alarm sounded. Interview with the Executive Director (ED) on 11/19/25 at 5:48pm revealed: -She was aware that the exit doors had to have sounding devices. -She was not aware that the exit alarm devices on the doors had to be continuous. -The PCAs and MA were responsible for checking the door and making sure all residents were accounted for when the alarm sounded. -She was not aware of any of the residents in the locked unit attempting to open any of the exit doors	D 067		
D 079	IOA NCAC 13F .0306 (a)(5) Housekeeping and Furnishings IOA NCAC 13F ,0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards, Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER]SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 079		D 079		

Continued From page 7 existing facilities.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure residents were free from hazards including a bottle of wound cleansing spray in a resident bathroom in the Special Care Unit (SCU).

The findings are:

Observation of resident room #403 on 11/18/25 at 8:31 am revealed:
-There was a spray bottle of wound cleanser on the counter of the resident's bathroom.
-There was a housekeeper cleaning the room and the bathroom.
-The wound cleanser remained in the bathroom after the housekeeper finished cleaning the residents room.

Interview with the facility's contracted primary care provider (PCP) on 11/19/25 at 5:30pm revealed:
-Wound cleanser should be locked up and not left where a resident could access it.
-The residents in the SCU had dementia and could get into the wound cleanser.
-She did not think the wound cleanser would harm a resident, even if swallowed, but she definitely did not want it left around.

Interview with the housekeeper on 11/19/25 at 9:21 am revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 079	Continued From page 8 -She had only been working for one month and was trained by another housekeeper, -She cleaned resident rooms and bathrooms every day. -She had not been told what to do if she found something like the wound cleanser in a resident's room or bathroom. -She had seen the wound cleanser in a resident's bathroom before, but she did not recall seeing a wound cleanser the day before, 11/18/25. Interview with a personal care aide (PCA) on 11/19/25 at 9:30am revealed: -The hospice nurse did wound care for residents. -The resident who resided in resident room #403 did not have wounds. -She was trained to remove items like wound cleanser if she found any in a resident's room, -Wound cleanser was stored with medications in the medication room in a locked cabinet. Interview with a medication aide (MA) on 11/19/25 at 9:38am revealed: -Wound cleanser was not allowed to be left in a resident room or in the bathroom because it was a SCU, -The resident who resided in resident room #403 did not have any wounds. -The resident who resided in room #403 could not get out of bed without assistance, but another resident could wander in and drink it or spray it. -The wound cleanser could have been used for another resident, carried into room #403 and accidentally left in the resident bathroom. Interview with a second MA on 11 Il 9/25 at 10:35am revealed: -The resident who resided in resident room #403 did not have a need for wound cleanser. -The MAs used wound cleanser and locked it	D 079		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(M) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SPRING ARBOR OF GREENSBORO	5125 MICHAUX ROAD GREENSBORO, NC 27410

0(4) ID pREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	p FIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE

D 079	Continued From page 9 back in the medication room; it was not supposed to be left in a residents room, -The PCAs and the MAs were supposed to keep an eye out for items like wound cleanser that should not be in a resident's room in the SCIL -The residents in the SCU went into each other's rooms and could have drank the wound cleanser or sprayed it on another resident. Interview with the Special Care Unit Coordinator (SCC) on 11/19/25 at 10:51 am revealed: -She was in and out of the residents' rooms every day. -Wound cleanser should not be left in a resident's room or bathroom. -If a wound cleanser was used in a resident's room it was supposed to be brought back to the medication room and locked back up. -The resident who resided in room #403 did not have any wounds. -The hospice nurse probably used the wound cleanser on another resident and then left it in resident room #403. -She did not know if the housekeeper was trained to look for items in residents' rooms and to notify the MAs or her if they saw something. -The PCAs and the MAs were trained and were responsible for keeping an eye out for items like medications that should not be left in a resident's room. -She was concerned that any resident could pick up the spray and spray it into their eyes or drink it. Interview with the Resident Care Coordinator (RCC) on 11/19/25 at 4:15pm revealed: -She went to the SCU first thing every day and walked in and out of different residents' rooms. -She looked for items like medications, soaps and cleaners in the resident rooms and bathrooms. -She looked for items because she did not want a	D 079		

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	HAL041088	A. BUILDING:_____ B. WNG_____	41/19/2025

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D 079	Continued From page 10 resident to ingest something they were not supposed to have. -Staff were trained to remove items like cleaner, soaps and medications from the residents' rooms. -She thought the housekeeper was also trained not to leave items and to report any items she found. -She was not sure why there was wound cleanser in resident room #403, Interview with the Executive Director on 11/19/25 at 5:50pm revealed: -The facility did not use a spray wound cleanser; she thought maybe a hospice nurse brought it in and left it in the residents' bathroom. -All chemicals should be locked up; wound cleanser was like a soap and should have been locked up. -She was afraid a resident might ingest the cleanser. -The housekeeper was new and might not have known to look for items in the residents' bathrooms. -The staff knew not to leave items like the wound cleanser in a resident bathroom. -She expected staff to remove the cleanser when they used it or if they found it. Based on observations, interviews and record reviews it was determined that the resident who resided in resident room #403 was not interviewable.	D 079		
D 235	IOA NCAC 13F .0703 (b & c) Tuberculosis Testi Medical Exam & Immunizatio IOA NCAC 13F 0703 Tuberculosis Test, Medical Examination And Immunizations	D 235		

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D 235	Continued From page 11 (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facilitYI except in the case of emergency admission. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure there was a medical examination completed annually for 1 of 5 sampled residents (#1 The findings are: Review of Resident #1's FL-2 dated 07/15/24 revealed diagnoses included dementia, hypertension, coronary artery disease, and chronic pulmonary embolism. Review of Resident #1 •s resident register revealed an admission date of 06/17/24 Review of Resident #1's record on 11/18/25	D 235		

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D 235	Continued From page 12 revealed there was an FL-2 dated 07/15/24. Interview with the Resident Care Coordinator (RCC) on 11/19/25 at 9:01am revealed: -She was responsible for ensuring the FL-2 was updated annually. -She sent the FL-2 to the primary care provider (PCP) on 10/16/25 and had not received it back. -It was difficult for her to receive documents from the PCP. -The facility moved to a new system and the due date for the FL-2 had changed Interview with the Executive Director (ED) on 11/19/25 at 9:27am revealed: -The RCC was responsible for ensuring the FL-2 was updated annually. -She expected the FL-2s to be updated annually. Attempted telephone interview with Resident #1 's PCP on 11/19/25 at 9: 14am was unsuccessful.	D 235		
D 273	IOA NCAC 13F .0902(b) Health Care IOA NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 5 sample residents (#5) who had an order for daily weights. The findings are:	D 273		

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D 273	Continued From page 13 Review of Resident #5 's current FL-2 dated 08/19/25 with revealed: -Diagnoses included congestive heart failure (CHF) and metabolic encephalopathy. -There was an order to weigh Resident #5 daily due to his diagnosis of CHF and an as-need diuretic for weight gain. Review of Resident #5's electronic medication administration record (eMAR) for September 2025 revealed: -There was an entry to weigh Resident #5 daily and notify the primary care provider (PCP) for a weight gain of 3 pounds overnight or 5 pounds in 1 week. -There was documentation that the daily weights were not completed 5 of 30 opportunities. -There were no exceptions documented on the eMAR of why the weights were not taken. Review of Resident #5's eMAR for October 2025 revealed: -There was an entry to weigh Resident #5 daily and notify the PCP for a weight gain of 3 pounds overnight or 5 pounds in 1 week. -There was documentation that the daily weights were not completed 17 of 31 opportunities, -There were no exceptions documented on the eMAR of why the weights were not taken. Review of Resident #5's eMAR for November 2025 from 11/01/25 - 11/17/25 revealed: •There was an entry to weigh Resident #5 daily and notify the PCP for a weight gain of 3 pounds overnight or 5 pounds in 1 week. -There was documentation that the daily weights were not completed 2 of 17 opportunities. -There were no exceptions documented on the eMAR of why the weights were not taken.	D 273		

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D 273	Continued From page 14 Review of Resident #5's progress notes for September, October, and November 2025 on 11/18/25 revealed there was no documentation the PCP was notified that the daily weights were not completed 5 times in September, 17 times in October, or 2 times in November 2025. Interview with Resident #5 on 11/19/25 at 11 :30am revealed he was supposed to be weighed daily but could not remember if he missed any days. Interview with a medication aide (MA) on 11/19/25 at 11 :45am revealed. -The MAs were responsible for weighing Resident #5 daily. -She could not recall if any of the days Resident #5 was not weighed were days that she was the MA for him. -The scale was broken at one point, but she could not recall for how long, and there was not another scale to use. Interview with a second MA on 11/19/25 at 12:15pm revealed: -The MAs were responsible for weighing Resident #5 daily. -She did not typically work on the Assisted Living side of the facility but remembered weighing Resident #5 because she had to administer his as-needed diuretic based on that weight. -She did not recall when the scale was brokem Interview with the Assistant Resident Care Coordinator (ARCC) on 11/19/25 at 4:15pm revealed: -The MAs were responsible for weighing Resident #5. -She was not aware that some of the ordered daily weights were not completed.	D 273		

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Continued From page 15

-She remembered the scale was broken for a shon period of time, but she could not recall when or for how long.
-There was not another weight scale in the facility to use.
-The Resident Care Coordinator (RCC) did eMAR audits checking for missed orders, which included weights.
-She expected the MAs to follow the physician's order.

Interview with the RCC on 11/19/25 at 4:47pm revealed.
-The MAs were responsible for weighing Resident #5 as ordered by the PCP.
-She completed eMAR audits every three months.
-The last audit she completed was in early September 2025.
-She was not aware there were daily weights not documented in September 2025, October 2025, and November 2025 for Resident #5.
-She recalled that Resident #5 was refusing weights in October 2025 but could not recall how many times.
-She believed the PCP reviewed the vital signs frequently and if she was concerned, she would have notified her.
-She expected the MAs to let the PCP know if they did not weigh Resident #5.

Telephone interview with Resident #5's PCP on 11/19/25 at 5:28pm revealed.
-Resident #5 had the daily weight order because of his CHF diagnosis.
-She was not aware there were days in September, October, and November 2025 that Resident #5 was not weighed.
-She was concerned that the as-needed diuretic would not be given if Resident #5 had a weight

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D 273	Continued From page 16 gain and the resident could then have an exacerbation of his CHF -She was concerned because her goal for Resident #5 was to reduce his daily weights to weekly weights and if he is not getting weighed, she could not accurately decide to change the daily weights order. -She expected to be notified when Resident #5 was not weighed Interview with the Administrator on 11 Il 9/25 at 5:48 pm revealed: -The MAs, ARCC and RCC were responsible for making sure the daily weights were completed. -She was not aware Resident #5 had an order for daily weights. -She was not aware that Resident #5 had days in September, October and November that he was not weighed. -The weight scale was broken at one point but it was fixed the next day. -The RCC did eMAR audits, but she could not recall how often. -She expected the order to be followed and to notify the PCP if the ordered weight was not completed.	D 273		
D 283	IOA NCAC 13F 0904(a)(2) Nutrition and Food Service IOA NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference,	D 283		

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D 283	Continued From page 17 including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food was protected from contamination related to foods stored in the walk-in cooler that were not labeled or dated, food with mold growth, and expired food, debris on floors, debris on the stove top, storage bins with debris in them, and a dirty grill. The findings are: Observation of the walk-in cooler on 11/18/25 at 9:44am revealed: -There was a large open container of salad dressing that expired on 10/02/25. -There was a large open container of mustard that was not dated. -There were 7 pitchers of liquid that were not labeled or dated. -There was a large clear container filled with fruit that was labeled 10/11 with no year. -There was a large clear container that was labeled 11/16 tomato sauce, with no year. -There was a large open bag of carrots that was not sealed or dated. -There was a box with a green pepper that contained mold with an opening at the bottom of	D 283		

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D 283	Continued From page 18 the green pepper. -There was a box with ten 12 cup yogurt packages that expired 11/07/25. -There was a container of strawberries that had mold growth on the strawberries. -There was a large open container of mayonnaise that was not dated with the open date, -There was a large open container of sweet pickle relish that was not dated with the open date. -There was a 5-pound container of sour cream that was not dated with the open date. -There was a 2-pound container of garlic that was not dated with the open date. -There was a I-pound container of beef base that was not dated with the open date. -There was a 4.5-pound container of maraschino cherries that was not dated with the open date. -There was a 2-pound container of horseradish that was not dated with the open date and had an expiration date of 05/18/25. -There was a large open bag of shredded cheese that was not dated with the open date. Observation of the dry food storage on 11/18/25 at 9:52am revealed. -There were 3 cases of water sifting directly on the floor. -There were several buns in packages with an expiration date of 09/29/25. Observation of the walk-in freezer on 11/18/25 at 9:54 am revealed: -There was a package of French fries open to the air that was not dated. -There was a Styrofoam to-go container that had a brown substance with frozen crystals and "for Thur 11-20" handwritten on the top. -There was a Styrofoam to-go container that had yellow substance with frozen crystals with "for Thu 11-20" handwritten on the top.	D 283		

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D 283	Continued From page 19 Observation of the kitchen on 11/18/25 at 9:55am revealed: -There was a build up Of food, debris and a black layer on the cast-iron burners on the stove, -There was a grill with had a pan setting on it; there were cans of food spray, spices and other food items on the pan. -There was a lip on the front of the grill that had a buildup of debris, and a yellow film that was sticky to the touch. -There was a yellow film and yellowish drips that were sticky to the touch running down the legs of the grill. -There was a missing panel on the side of the stove and the insulation and there were exposed wires. -There were debris, food and black specks on the floors behind the stove, grill, prep tables and ice machine. -There were multiple storage bins under a prep table; each bin contained portion-controlled condiments. -There were pieces of packaging, opened condiments and debris at the bottom of the bins. Review of the Environmental Health Services (EHS) inspection report dated 04/30/25 revealed: -The kitchen sanitation score was 95. -There was a 1.5-point deduction received under foodborne illness risk factors due to packaged meats being opened but undated as to when they were opened; it was a repeat occurrence. -There was a 0 5-point deduction received under good practices to control physical objects in food due to cooking equipment that needed to be cleaned, and debris on low shelves and inside drawers; it was a repeat occurrence, -There was a 1 a-point deduction received under good practices to control physical objects in food	D 283		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0(2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 283	Continued From page 20 due to floors needing to be cleaned better; it was a repeat occurrence. Interview with the Dietary Manager (DM) on 11/18/25 at 10:00am revealed: -He was not aware of the expired food. -He was not aware the green pepper and strawberries had mold on them. -The kitchen staff were responsible for checking for expired food. Interview with the DM on 11/19/25 at 2:50pm revealed: -All food should be labeled and dated with the month, day, and year they were opened. -He was not aware that the open food items were not dated. -He was not aware of the open bags of food. -All food should be resealed. -The buns were removed from the freezer on 11/05/25 for the lunch meal on 11/07/25, -He did not put a removed from freezer label or date on the buns, -The floors in the kitchen were swept and mopped at the end of the workday. -The grates on the stovetop were on a weekly schedule to be removed and cleaned once or twice a week. -He had removed the grates and cleaned them this morning, 11/19/25. -The grill worked but was not used that often; the last time it was used was over a month ago. -The missing panel on the stove had been like that since he had worked at the facility. -The storage bins had been cleaned last week and were usually cleaned once a week, -There was a daily and a weekly cleaning schedule for the kitchen staff to follow. -The staff initialed the cleaning schedule once complete, but he did not keep them and "tossed"	D 283		

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D 283	Continued From page 21 them each week. -He looked at items in the kitchen everyday to see if they were being cleaned by the staff. Interview with the Executive Director (ED) on 11/19/25 at 5:48pm revealed. -The DM was responsible for ensuring food was covered and labeled. -The kitchen staff were new employees, and she expected the DM to provide training. -She expected the DM to look at the walk-in cooler and freezer daily, upon arrival, to ensure all foods are labeled, dated and not expired. -She went into the kitchen at least once a day and she met with the DM every morning to discuss the dietary department. -The kitchen staff cleaned the kitchen every evening before they left. -She looked around at the general sanitation in the kitchen, but she did not go through the kitchen and do an inspection. -The floors did always look dirty; it looked like the staff were just hitting the 'high spots". -She was not sure about the cleaning schedules and if the staff were following one. -She expected the DM to make sure the sanitation in the kitchen was properly maintained.	D 283		
D 286	IOA NCAC 13F 0904(b)(1) Nutrition and Food Service IOA NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers.	D 286		

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D 286	Continued From page 22 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure mealtime table service included a place setting consisting of a knife, fork, and spoon in the Special Care Unit (SCU) and the locked unit in the Assisted Living (AL). The findings are: Review of the lunch menus for 11/18/25 and 11/19/25 revealed: -On 11/18/25, the lunch meal was pork loin, cinnamon sweet potatoes, cauliflower a diner roll and butterscotch pudding, -On 11/19/25, the lunch meal was chickenr pinto beans, buttered corn and ice cream. I. Observation of the lunch meal in the SCU on 11/18/25 at 1199am revealed: -There were 13 preset place settings with only a fork; spoons and knives were not provided. -The residents were served sliced pork, cauliflower, cinnamon sweet potatoes, and butterscotch pudding. -The residents ate their butterscotch pudding with their forks. Observation of the lunch meal in the SCU on 11/19/25 at 11130am revealed: -There were 13 preset place settings with only a fork; spoons and knives were not provided. -The residents were served chicken on a bun with lettuce and tomato, tater tots and ice cream.	D 286		

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D 286	Continued From page 23 -The residents were given plastic spoons to eat their ice cream with. Interview with a personal care aide (PCA) on 11/19/25 at 2:15pm revealed: -The PCAs set the tables in the SCU. -The kitchen staff sent forks, knives, and spoons to the SCU -The PCAs only set the fork for the residents in the SCU to use because that was the only utensil the residents used. -No one ever said anything to her about giving the residents a spoon and a knife. Interview with the Dietary Manager (DM) on 11 Il 9/25 at 2.'50pm revealed: -The residents were supposed to get a fork, knife and a spoon at their place setting. -There was enough silverware available to give each resident a fork, knife and a spoon. -The kitchen sent silverware to the SCU, but it did not always come back to be washed. Interview with the Special Care Unit Coordinator (SCC) on 11/19/25 at 2:21pm revealed: -She monitored meals in the SCU at least once a day. -The PCAs gave the residents a spoon and a fork; the residents did not get knives. -The SCU staff cut up the residents' food before they gave it to the residents. -The residents in the SCU did not know what to do with a knife. -The residents in the SCU would play with a knife and not know what to do with it and she did not want them to get injured. -The residents should have been given spoons. Interview with the Executive Director on 11/19/25 at 5:45pm revealed:	D 286		

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D 286	Continued From page 24 -She expected the staff to give each resident in the SCU a forkY knife and a spoon at each meal, -Someone had reported the residents were not getting a full place setting to the SCC sometime in the spring. -She provided each facility staff with a copy of the rule after the complaint. -She was disappointed the staff were not providing spoons and knives for the residents in the SCU to eat with. 2. Observation of the lunch meal service in the locked unit in the AL on 11/18/25 at 11:37am revealed: -The residents were served pork loin, cauliflower, and roasted sweet potatoes cut in half. -The residents had a fork and spoon but were not provided with a knife. Observation of the lunch meal service in the locked unit in the AL on 11/19/25 at 11:35am revealed: -The residents were served bone-in chicken, beans, corn and a roll. -The residents had a fork and spoon but were not provided with a knife. Interview with a personal care aide (PCA) on 11/19/25 at 12:04pm revealed: -The residents were not provided with a knife because they did not use them. -The clinical staff would assist with cutting up their food. Interview with the Resident Care Coordinator (RCC) on 11/19/25 at 2:30pm revealed: -She was aware that the residents did not get a knife with their meal. -Most of the residents could not use the knives and needed assistance with eating.	D 286		

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D 286	Continued From page 25 -She had a supply of knives that she pulled from her desk drawer. -The place settings came from the kitchen, and she expected the staff to ask the kitchen staff for the correct place settings. Interview with Dietary Manager (DM) on 11/19/25 at 2:50pm revealed: -Every resident should get a complete place setting to include a fork, spoon, and knife. -There had been an issue with the residents taking the silverware with them to their rooms. -He expected the clinical staff to request any missing place setting. Interview with the Executive Director (ED) on 07/17/25 at 5:15pm revealed: -She was not aware the residents in the locked unit in the AL were not provided with a knife. -She expected every resident to be provided with a fork, knife, and spoon during meals.	D 286		
D 309	IOA NCAC 13F 0904(e)(3) Nutrition and Food Service IOA NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by:	D 309		

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D 309	Continued From page 26 Based on observations, record reviews, and interviews, the facility failed to maintain a current listing of residents with physician ordered therapeutic diets for guidance of food service staff for 2 of 4 residents (#6 and #7). The findings are: Observation of the kitchen on 11/18/25 at 9:40am revealed. -There was a bulletin board in the kitchen that listed the diets including, mechanical soft diet, consistent carbohydrate diet, diabetic diet, and pureed diet. -Under each diet listed there was a piece of paper with a resident's name, picture, and the ordered diet check off. -Some of the residents had multiple pieces of paper under more than one diet. -There were multiple lists with residents' names and their diets tapped to the serving table for the hot foods. -The names and diets on the bulletin board did not match the names and diets on the list on the serving table for the hot foods. 1. Review of Resident #6's current FL-2 dated 07115/25 revealed: -Diagnoses included cognitive communication deficit, hypertension and gastroesophageal reflux disease (GERD). -There was an order for a regular diet. Observation of the bulletin board in the kitchen on 11/18/25 at 9:40am revealed Resident #6 was listed as having an order for a mechanical soft (MS) diet with chopped meats. Observation of the diet list on the serving table for the hot foods revealed Resident #6 was listed as	D 309		

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D 309	Continued From page 27 having an order for a MS diet with chopped meats. Review of the facility's diet list provided on 11/18/25 revealed Resident #6 was listed as having an order for a regular diet, Refer to the interview with a cook on 11/18/25 at 9:50am. Refer to the interview with a personal care aide (PCA) on 11/19/25 at 215pm. Refer to the interview with the Dietary Manager (DM) on 11/19/25 at 2:50pm. Refer to the interview with the Assistant Resident Care Coordinator (ARCC) on 11/19/25 at 4:15pm. Refer to the interview with the Executive Director (ED) on 11/19/25 at 5:50pm 2. Review of Resident #7's current FL-2 dated 03/27/25 revealed: -Diagnoses included dementia and diabetes. -There was an order for finger foods. Review of Resident #7's diet order dated 11/18125 revealed there was an order for finger foods and a carbohydrate-controlled (CC) diet. Observation of the bulletin board in the kitchen on 11 "8/25 at 9:40am revealed Resident #7 was listed as having an order for a CC diet only. Observation of the diet list on the serving table for the hot foods revealed Resident was listed as having an order for a Finger Food diet only. Review of the facility's diet list provided on	D 309		

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11/18/25 revealed Resident #7 was listed as having an order for a Finger Food diet.

Refer to the interview with a cook on 11/18/25 at 9:50am.

Refer to the interview with a personal care aide (PCA) on 11/19/25 at 2:15pm.

Refer to the interview with the Dietary Manager (DM) on 11/19/25 at 2:50pm.

Refer to the interview with the Assistant Resident Care Coordinator (ARCC) on 11/19/25 at 4:15pm.

Refer to the interview with the Executive Director (ED) on 11/19/25 at 5:50pm

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Interview with a cook on 11/18/25 at 9:50am revealed she followed the therapeutic diet list that was tapped to the hot food serving line when she plated food.

Interview with a PCA on 11/19/25 at 2:15pm revealed she followed the diet list on the bulletin board when she served food to the residents.

Interview with the DM on 11/19/25 at 2:50pm revealed:
-The ARCC gave him a copy of the individual diet orders signed by the physician.
-He placed the diet order sheets in a binder in the kitchen
-The ARCC was responsible for maintaining the diet list on the bulletin board.
-He wrote out the list on the hot food serving line for the cooks to reference when they were plating the food.
-He used the signed diet orders to write out the diet list on the hot food serving line.

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D 309	Continued From page 29 Interview with the ARCC on 11/19/25 at 4: 15pm revealed: -She was responsible for updating the diet orders in the facility's electronic charting system. -She also updated the diet list on the bulletin board in the kitchen. -When the physician signed a new diet order sheet, she updated the diet in the electronic charting system and changed the diet list on the bulletin board. -Sometimes a signed diet order would be given directly to the DM, and she would not know there had been a change. -She was working on simplifying the diet list and trying to make it easier for the staff to follow. Interview with the ED on 11/19/25 at 550pm revealed: -The ARCC was supposed to monitor diet orders and diet order changes, -The ARCC made a copy of the diet order and gave it to the kitchen staff. -The ARCC entered the diet orders into the electronic charting system and updating the diet list on the bulletin board. -The DM was responsible for creating a diet list and keeping it current. IOA NCAC 13F 0904(e)(4) Nutrition and Food Service	D 309		
D 310	IOA NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquid* shall be served as ordered by the resident's physician.	D 310		

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D 310	Continued From page 30 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that therapeutic diets were served as ordered for 2 of 4 sampled residents (#3 and #7), who had an order for a pureed diet (#3) and finger foods (#7), The findings are: Review of the lunch menus for the regular diets on 11/18/25 and 11/19/25 revealed: -On 11/18/25, the lunch meal was pork loin, cinnamon sweet potatoes, cauliflower a diner roll and butterscotch pudding. -On 11/19/25, the lunch meal was chicken, pinto beans, buttered corn and ice cream 1. Review of Resident #3s current FL-2 dated 11/18/25 revealed: -Diagnoses included Alzheimer's disease. - There was an order for a pureed diet. Review of the therapeutic diet menu for the lunch meal on 11/1 8/25 revealed the pureed diets were to be served 3 ounces of pureed pork with 2 ounces of gravy, half a cup pureed spinach, half a cup of pureed cauliflower and pudding. Observation of the lunch meal on 11/18/25 from 11:30am to 12:30pm revealed: -Resident #3 was served half a cup of pureed pork without gravy, half a cup of pureed spinach, half a cup of mashed potatoes without gravy and no dessert. -Resident #3 ate 100 percent of her spinach, and beef and 75 percent of her mashed potatoes. Review of the therapeutic diet menu for the lunch meal on 11/1 9/25 revealed the pureed diets were	D 310		

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D 310	Continued From page 31 to be served 8 ounces of pureed chicken, half a cup of pureed pinto beans, half a cup of mashed potatoes with gravy and ice cream. Observation of the lunch meal on 11/19/25 from 11 :30am to 12:22pm revealed: -Resident #3 was served half a cup of pureed chicken without gravy, half a cup of mashed potatoes without gravy and pudding. -Resident #3 ate 75 percent of her chicken, less than 10 percent of her mashed potatoes and 100 percent of her pudding. Interview with Resident #3's hospice nurse on 11/19/25 at 10:00am revealed: -Resident #3 was ordered a pureed diet due to swallowing issues. -Her expectation was Resident #3 would be served a puree diet as ordered. -Resident #3 should have been served everything that was on the pureed diet menus so that she got all of the nutrition she needed, Interview with the Dietary Manager (DM) on 11/19/25 at 2:50pm revealed: -The kitchen staff had worked at the facility for a while, so they knew what to prepare for the pureed diets. -The therapeutic diet menus were kept in a book in the kitchen if the staff needed to reference them. -The purees were served the same menu as the regular diets. -The food was pureed to a baby food consistency, so it was soft enough to swallow. -He did not realize the residents on a pureed diet were not being served the correct food per the therapeutic diet menu. Based on observations, interviews, and record	D 310		

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D 310	Continued From page 32 reviews it was determined Resident #3 was not interviewable. Refer to the interview with a cook on 11/18/25 at 9:50am. Refer to the interview with the Special Care Unit Coordinator (SCC) on 11/19/25 at 2:21pm. Refer to the interview with the Executive Director (ED) on 11/19/25 at 5:50pm. 2. Review of Resident #7s current FL-2 dated 03/27/25 revealed: -Diagnoses included dementia. -There was an order for finger foods. Review of Resident #7's diet order dated 11/18/25 revealed there was an order for finger foods. Review of the therapeutic diet menu for the lunch meal on 11/18/25 revealed the residents with a finger food order were to be served 3 ounces of cut pork loin, half a cup of cinnamon sweet potatoes, seasoned zucchini, and a brownie for dessert. Observation of the lunch meal on 11/18/25 from 11:30am to 1230pm revealed: -Resident was served sliced pork loin on two dinner rolls, half a baked sweet potato and no dessert. -Resident ate 100 percent of her meal. Review of the therapeutic diet menu for the lunch meal on 11/19/25 revealed the residents with a finger food order were to be served 3 ounces of baked chicken, half a cup of pinto beans, half a cup of tater tots, lettuce and tomato and an ice cream sandwich.			

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D 310	Continued From page 33 Observation of the lunch meal on 11/19/25 from 11:30am to 12:22pm revealed: -Resident #7 was served a chicken patty on a bun, lettuce, tomato and tater tots and a cookie. -Resident #7 ate 50 percent of her chicken, 100 percent of her tater tots, bun, lettuce, tomato and cookie. Telephone interview with Resident #7's primary care provider (PCP) on 11/19/25 at 5:30pm revealed: -Resident #7 had an order for finger foods because it was the best option for her because it was easy for her to pick up food and feed herself. -She had not reviewed the therapeutic menu, but she expected Resident #7 to be served every item on the therapeutic menu or given an alternative option. -If Resident #7 was not being served every item on the therapeutic diet menu then she was not getting enough proteins and vegetables while on the finger food diet. InteNiew with the Dietary Manager (DM) on 11/19/25 at 2:50pm revealed: -The residents with a finger food diet order were served their food on buns, rolls or bread. -The kitchen staff would change out foods they thought the residents could not pick up. -The kitchen staff had worked at the facility for a while, so they knew what finger foods to prepare. -The therapeutic diet menus were kept in a book in the kitchen if the staff needed to reference them. -The kitchen staff would depend on him for guidance on what to serve for a finger food if in doubt as to what was supposed to be given. -He did not realize the residents with a finger food order were not getting every item on the	D 310		

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therapeutic diet menu.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interuiewable.

Refer to the interview with a cook on 11/18/25 at 9:50am.

Refer to the interview with the Special Care Unit Coordinator (SCC) on 11/19/25 at 2:21 pm.

Refer to the interview with the Executive Director (ED) on 11/19/25 at 5:50pm.

Interview with a cook on 11/18/25 at 9:50am revealed:
-She did not use the therapeutic diet menus when she prepared foods for the residents.
-She prepared the food items on the regular menu and modified them for the therapeutic diets. -She knew what to foods prepare for the therapeutic diets from experience.
-The DM had a meeting everyday and verbally went over the regular menu and the therapeutic menu.

Interview with the SCC on 11/19/25 at 2:21am revealed:
-She observed one meal a day in the SCIL -She did not have a copy of the therapeutic diet menus, so she did not compare the residents' plates to the menu.
-It was the kitchen staff's responsibility to ensure they were following the residents' diets per the therapeutic diet menu.

Interview with the ED on 11/19/25 at 5:50pm revealed:
-She expected the kitchen staff to follow the

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D 310	Continued From page 35 therapeutic diet menus. -The DM was responsible for ensuring the therapeutic diet menus were being followed and served correctly. -If a resident was not served the correct therapeutic diet, it could harm the resident. -If menu items were eliminated from the residentS meals, then the residents were not getting the proper nutrition and could decline physically,	D 310		