STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086001	A. BUILDING: _____ B. WING _____	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CARE	139 APEX LANE MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a annual and follow-survey from 03/10/26 to 03/11/26.	D 000		
D 083	10A NCAC 13F .0306 (a)(9) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based observations and interviews, the facility failed to provide window blinds that were not damaged in 4 of 24 sampled resident rooms (A4, A8, B22, B24). The findings are: Observation of resident room A4 on 03/10/26 at 9:10am revealed: -One resident resided in the room. -The room had one window that faced the facility's parking lot. -The window had vertical blinds that covered part of the window. -There were 4 slats missing from the vertical blinds. Interview with the resident that resided in room A4 on 03/10/26 at 1:57pm revealed:	D 083		

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D 083	Continued From page 1	D 083		

-She would like her blinds to be fixed or replaced.
-She was aware someone could see in her room from outside.
-She did not feel like she had privacy.

Observation of resident room A8 on 03/10/26 at 9:12am revealed:
-Two residents resided in the room.
-The room had one large window that faced the back of the facility.
-The window had vertical blinds that covered part of the window.
-There was one slat missing and a 2nd slat, broken in half, missing from the vertical blinds.

Interview with one of the residents that resided in room A8 on 03/10/26 at 1:59pm revealed:
-He knew people could see into the window from outside.
-He had not mentioned the broken blinds to staff.

Observation of resident room B22 on 03/10/26 at 9:57am revealed:
-Two residents resided in the room.
-The room had one window that faced the back of a facility.
-The window had vertical blinds that covered part of the window.
-There were 4 slats missing from the vertical blinds.

Interview with one of the residents that resided in room B22 on 03/10/26 at 9:58am revealed:
-He knew people could see into the window from outside.
-Not having privacy bothered him.
-He had mentioned the broken blinds to staff in the past, but nothing was done.

Observation of resident room B24 on 03/10/26 at

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D 083	Continued From page 2 10:00am revealed: -One resident resided in the room. -The room had one window. -The window had vertical blinds that covered half of the window. -There were multiple slats missing from the vertical blinds. Interview with the resident that resided in room B24 on 03/10/26 at 1:44pm revealed: -He knew people could see into the window from outside. -He would move to the other side of his room when changing so no one from outside the window would see him. -He had asked staff, in the past, about fixing the vertical blinds but nothing had been done. Interview with the Resident Care Coordinator (RCC) on 03/11/26 at 3:20pm revealed: -She had been made aware of the broken blinds in some resident rooms. -The Administrator was responsible for replacing broken blinds. -Some of the blinds were broken by residents when they opened their windows. Interview with the Administrator on 03/11/26 at 3:25pm revealed: -She was aware of the broken blinds in residents' rooms. -She had added curtains and replaced the tabs in the vertical blinds, but the tabs easily fell out. -It was the staff's responsibility to notify her when they saw broken blinds. -She was responsible for ensuring all resident rooms had blinds that fully closed.	D 083		

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D 091	Continued From page 3	D 091		
D 091	10A NCAC 13F .0306 (b)(5)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (5) a minimum of one chair that is comfortable as preferred by the resident, which may include a rocking or straight chair, with or without arms, that is high enough for the resident to easily rise without discomfort; (6) additional chairs available, as needed, for use by visitors; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide a comfortable chair for each resident in 6 of 24 resident's rooms (A2, A4, B17, B19, B20 and B21). The findings are: Observation of resident room A2 on 03/10/26 at 9:00am revealed: -Two residents resided in the room. -One resident had a chair at the foot of the bed. -One resident had a wheelchair beside the bed. Observation of resident room A4 on 03/10/26 at 9:05am revealed: -Two residents resided in the room. -There were no chairs in the room.	D 091		

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D 091	Continued From page 4 Interview with one of the residents in room A4 on 03/10/26 at 9:10am revealed: -He never had a chair beside his bed. -When he was not lying down, he sat on his bed or in his wheelchair. -He would like a chair in his room. -He had not requested a chair from staff. Observation of resident room B17 on 03/10/26 at 9:15am revealed: -Two residents resided in the room. -There was one chair located beside one of the residents' bed. -The other resident did not have a chair. Observation of resident room B19 on 03/11/26 at 9:40 am revealed: -Two residents resided in the room. -There were no chairs in the room. Interview with one of the residents in room B19 on 03/11/26 at 9:45am revealed: -She never had a chair in her room. -It would be nice to have a chair to sit in when family visit. -She sat on her bed most of the time. -She had not requested a chair from staff. Observation of resident room B20 on 03/11/26 at 10:00am revealed: -Two residents resided in the room. -There were no chairs in the room by either bed. Observation of resident room B25 on 03/11/26 at 10:15am revealed: -One resident resided in the room. -There was no chair in the room. Interview with one of the residents who resided in room B25 on 03/11/26 at 10:20am revealed:	D 091		

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D 091	Continued From page 5 -She would like a chair in her room. -Her family had to sit on her bed when they visited. -When not laying down she had to sit up in the bed. -She had not requested a chair from staff. Interview with the Resident Care Coordinator (RCC) on 03/11/26 at 3:20pm revealed: -She was made aware of the rule when she assumed the role of RCC in September 2025. -She was not aware some residents did not have chairs in their rooms. -No residents had requested a chair for their room. Interview with the Administrator on 03/11/26 at 3:30pm revealed: -She was aware that all residents should have a chair in their rooms. -All residents were offered a chair, but some declined. - It was her responsibility to ensure that each resident had a chair in their room.	D 091		