STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019022	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNMORE SENIOR LIVING OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 03/25/26 to 03/26/26.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 3 sampled residents (#1) including notifying their Mental Health Provider (MHP) about wandering behaviors at night. The findings are: Review of Resident #1's current FL-2 dated 10/27/25 revealed: -There was a diagnosis of dementia with delusional disturbances. -He was intermittently disoriented. -He wandered. -There was an order for melatonin 3mg (used for sleep) take 2 tablets every evening. Review of Resident #1's signed MHP's orders dated 12/08/25 revealed: -There was an order to discontinue melatonin 3mg take 2 tablets every evening. -There was an order to start trazodone 50mg (used as a sedative to treat insomnia) at bedtime.	D 273		

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Review of Resident #1's electronic progress note dated 02/24/26 at 3:17am revealed:
-Resident #1 was found standing over his roommate while his roommate was sleeping.
-When the medication aide (MA) asked Resident #1 what he needed, Resident #1 did not respond.
-Resident #1 was restless and began wandering in the hallway.

Review of Resident #1's electronic progress note dated 03/04/26 at 12:31am revealed:
-Resident #1 was in a female resident's room, and touched her inappropriately.
-Resident #1 became irritated when asked to stop and exit the female resident's room.

Review of Resident #1's electronic progress note dated 03/16/26 at 4:41am revealed:
-Resident #1 wandered in the facility for 3 hours.
-Resident #1 wandered into residents rooms whose bedroom doors were not closed.
-Resident #1 woke up three residents while he was wandering.

Review of Resident #1's electronic progress note dated 03/18/26 at 2:01am revealed:
-Resident #1 was going through his roommate's belongings, and ate his roommate's snacks.
-Resident #1 was anxiously pacing the hallway.

Review of Resident #1's electronic progress note dated 03/20/26 at 12:07am revealed:
-Resident #1 and his roommate were "having words" due to Resident #1 refusing to turn the overhead light off.
-Resident #1 and his roommate were redirected to their sides of the room, the overhead light was turned off and Resident #1's lamp was turned on.

Review of Resident #1's electronic progress note

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D 273	Continued From page 2 dated 03/20/26 at 4:39am revealed: -Resident #1 paced back and forth in the hallway as if he was searching for something. -When Resident #1 was asked what he was searching for, Resident #1 responded but what was said did not make sense. Review of Resident #1's psychiatry progress note dated 12/19/25 revealed: -Resident #1 had a history of insomnia and was recently started (12/08/25) on trazodone 50mg at bedtime. -Resident #1 reported sleeping pretty good. -Staff reported Resident #1 was sleeping pretty good. -Staff were to monitor sleep patterns and medication would be adjusted as necessary. Review of Resident #1's psychiatry progress note dated 02/13/26 revealed: -Resident #1 was currently taking trazodone 50mg at bedtime to manage insomnia. -Resident #1 was sleeping well. -Continue Resident #1's current medication regimen. -Monitor for changes in Resident #1's sleep patterns and effectiveness of trazodone. -Please contact the MHP if there were changes in Resident #1's sleep. Review of Resident #1's psychiatry progress note dated 03/13/26 revealed: -Resident #1 reported he was sleeping well. -Resident #1 was napping prior to MHP's visit. -Continue Resident #1's current medication regimen, trazodone 50mg at bedtime. -Monitor for changes in Resident #1's sleep patterns. -Please contact the MHP if there were changes in Resident #1's sleep.	D 273		

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D 273	Continued From page 3 Observation of Resident #1 on 03/25/26 between 9:00am and 1:00pm and between 3:00pm and 5:00pm revealed: -Resident #1 was observed sitting in his room. -Resident #1 was observed ambulating on the 200 hallway where he resided and the 300 hallway where the dining room and living room were. -Resident #1 was seen sitting in the dining room for lunch and dinner. Telephone interview with Resident #1's family member on 03/25/26 at 12:40pm revealed: -She visited Resident #1 at the facility. -Some days he would be alert and talkative, other days he would be confused and could not put words together to make a sentence. Interview with a personal care aide (PCA) on 03/26/26 at 8:18am revealed: -He worked first shift. -Resident #1 ambulated in the hallways. -He found Resident #1 in a female resident's room twice but the female resident was not in her room. -He redirected Resident #1 and removed him from the female resident's room. -He heard about the incident between Resident #1 and a female resident; he kept Resident #1 and the female resident separated. -He would involve Resident #1 in an activity to keep him busy; Resident #1 loved to read and listen to music. Telephone interview with the third shift MA on 03/25/26 at 2:38pm revealed: -Resident #1 walked up and down the hallway most nights. -Resident #1 would go into other residents'	D 273		

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rooms.
-Sometimes he saw Resident #1 going into other residents' rooms and he would stop him.
-Sometimes he saw Resident #1 coming out of other residents' rooms.
-One night, he found Resident #1 in a female residents' room touching her inappropriately.
-He removed Resident #1 from the female resident's room and Resident #1 became agitated.
-He and the PCA kept a closer watch on Resident #1 after he was found in the female resident's room.
-He found Resident #1 going through his roommate's items one night and eating his roommate's snacks.
-One night he wandered into another resident's room and woke the resident up.
-Resident #1 and the other resident became loud and caused two other residents to wake up and come outside their bedroom into the hallway to see what the noise was.
-He reported to the oncoming staff for first shift each morning; sometimes it was a MA and sometimes it was the Resident Care Coordinator (RCC).

Telephone interview with Resident #1's MHP on 03/25/26 at 2:44pm revealed:
-Her last visit to the facility was 03/13/26.
-She was made aware of Resident #1 touching a female resident on 03/13/26, during her on site visit.
-She would have instructed the staff to keep Resident #1 away from the female resident had she been notified of the incident the day it occurred.
-She expected to be notified of an incident of inappropriate behavior on the same day the incident occurred.

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D 273	Continued From page 5	D 273		

-She had not been told Resident #1 was not sleeping well, that he was up wandering the hallways, entering other residents' rooms during the night, and waking resident's up from their sleep.
-She changed his medication for insomnia from melatonin to trazodone on 12/08/25.
-If she had been made aware Resident #1 was not sleeping well, she would have increased his dosage of trazodone.
-She expected to be notified that Resident #1 was not sleeping well at night.

Interview with the RCC on 03/25/26 at 3:21pm revealed:
-When incidents happened on third shift, report was given to the first shift MA or her and the MHP would be called if needed.
-She did not typically call the MHP; she would let the MHP know what had happened with the residents on her monthly visits.
-The MHP came to her office on her monthly visits and get reports of the residents she would see.
-She did not notify the MHP about Resident #1 wandering in the hallway, standing over his roommate, or going into other residents' rooms.
-The MHP had access to the electronic progress notes and could see what was happening with all the residents.
-She notified the MHP of the incident on 03/04/26 regarding Resident #1 touching a female resident inappropriately on the MHP's monthly visit on 03/13/26.

Interview with the Administrator on 03/25/26 at 4:10pm revealed:
-The MHP had access to each resident's electronic progress notes that were entered by the staff.

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D 273	Continued From page 6 -All resident behaviors were documented in the electronic progress notes. -The MHP should read the electronic progress notes before coming to the facility. -The staff would report issues to the RCC or the Administrator and they would notify the MHP when she visited each month. -If there was a major issue with a resident, the RCC would reach out to the MHP that same day. -The RCC should have notified the MHP on 03/04/26 when the incident occurred and documented in the electronic progress notes about Resident #1 inappropriately touching a female resident. Attempted telephone interview with a third shift PCA on 03/25/26 at 11:00am was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. _____ The facility failed to notify the Mental Health Provider regarding a resident who was not sleeping at night, which led to the resident wandering the hallways, entering other residents' rooms, waking residents from their sleep, and touching a female resident inappropriately. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/25/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 10, 2026.	D 273		

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D 283	Continued From page 7	D 283		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A 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, 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 record reviews, observations, and interviews, the facility failed to ensure the kitchen and food storage areas were clean and free from contamination, including the reach-in and walk-in coolers, the dry pantry, and the beverage shelving. The findings are: Review of the Environmental Health Services (EHS) inspection report dated 08/13/25 revealed: -The facility received a score of 98.5.	D 283		

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D 283	Continued From page 8 -The inspector documented that the wire shelving in the left section of the three-door reach-in cooler was rusted and needed to be replaced. Observation of the reach-in cooler on 03/25/26 at 9:13am revealed: -The reach-in cooler had three doors. -Inside the first door, there was a plastic bag of cooked cabbage that was not labeled or dated to indicate when the cabbage was cooked. -There was also an open package of deli meat inside a plastic bag that was not labeled or dated to indicate when the cabbage was cooked. -There was debris on the bottom shelf. -Inside the third door, the wire shelving was rusted. -There were dried spillage and debris on each shelf. -The inside edge of the door had a build-up of dirt and grime. Observation of the reach-in cooler on 03/26/26 at 9:13am revealed: -The bag with the cabbage and deli meat was not in the cooler. -There was debris on the bottom shelf. -Inside the third door, the wire shelving was rusted. -There were dried spillage and debris on each shelf. -The inside edge of the door had a build-up of dirt and grime. Observation of the dry food storage pantry on 03/25/26 at 9:20am and on 03/26/26 at 9:13am revealed: -There was a build-up of dirt and grime on the floor of the pantry. -There were multiple dead insects on the floor. -There was a plastic storage drawer on the shelf.	D 283		

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D 283	Continued From page 9 -Inside the drawer were individual packets of sugar, sugar granules, and dead insects. Observation of the kitchen on 03/25/26 at 9:25am and on 03/26/26 at 9:13am revealed: -There was a set of metal shelves that contained a tea maker, a coffee maker, a plastic two-drawer storage unit, a cooler, and miscellaneous utensils. -There was rust noted on the metal shelves. -The plastic two-drawer storage unit had dried liquid and debris on the top and drawer handles, as well as inside each drawer, where coffee filters and tea bags were stored. Interview with a cook on 03/25/26 at 9:17am revealed: -She was not sure when the cabbage was prepared; the bag should have been labeled and dated. -She was not sure when the deli meat was opened; the bag should have been labeled and dated. -There was a cleaning schedule for the kitchen; she cleaned as she went. Observation of the bulletin board hanging on the kitchen wall on 02/25/26 at 9:22am revealed a blank daily cleaning checklist. Review of the daily kitchen cleaning checklist revealed: -The floors were to be swept after each meal and mopped at the end of the day. -Sweep and mop the pantry every Friday after the food truck delivery. -Sweep and mop under the reach-in cooler every Thursday. -All work counters were to be cleaned daily.	D 283		

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D 283	Continued From page 10 Telephone interview with the county's EHS on 03/25/26 at 1:49pm revealed: -Rust was a concern because of the risk of contamination. -If an item was stored on a rusted shelf, and then the item was placed on the food preparation table, it could increase the chance of contamination. -Any residue in the drawers could contaminate the coffee filters and tea bags. -Pests in the drawer with sugar packets had contaminated those packets and should not be used. -Opened deli meat should be documented and labeled when opened to ensure the deli meat was not used outside the recommended 7-day time frame because of the risk of listeria (food poisoning). -The cooked cabbage should be documented and labeled when prepared to prevent the food from being used outside the recommended 7-day time frame because of the risk of food-borne illness. Interview with a second cook on 03/26/26 at 8:55am revealed: -No one had told him specifically what to clean. -He took it upon himself to sweep the floor every day. -Staff were supposed to clean up what needed to be cleaned. -He had not noticed the spilled liquid and debris in the reach-in cooler or in the drawers where the tea bags and coffee filters were stored. -He did not use the individual sugar packets that were in the plastic storage drawer, so he had not noticed the dead insects. -He did not know if rusted shelving was a problem or not. -He had not completed a weekly cleaning schedule form.	D 283		

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D 283	Continued From page 11 Interview with the Dietary Manager (DM) on 03/26/25 at 10:05am revealed: -She had only been the DM for 3-4 weeks. -All dietary staff were responsible for cleaning every day. -She expected the kitchen to be swept and mopped daily. -The reach-in cooler should be cleaned every Friday. -If something was spilled, whoever caused the spillage should have cleaned it up at that time. -All food should be labeled and dated when opened so the dietary staff would know when to stop using it. -She knew there was rusty shelving in the kitchen and in the reach-in cooler; she did not know it could cause contamination. -She did not know there were dead insects in the pantry. -She expected staff to sweep up dead insects when seen. -She thought there was a cleaning schedule, but she was not sure where the cleaning schedule was located. Interview with the Administrator on 03/25/26 at 10:19am revealed: -She was usually in the kitchen at least twice a day and observed for cleanliness. -She had recently had a turnover in dietary staffing. -She knew there were rusted shelves in the reach-in cooler, and the county EHS had cited her for it. -She had replaced some of the reach-in cooler shelving, but not all of it, due to the cost. -She did not know shelving in the reach-in cooler, and the plastic storage drawers had spillage and debris.	D 283		

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D 283	Continued From page 12 -She expected any spillage/debris to be cleaned up when it was spilled by whoever did it. -The deli meat should have been placed in a plastic bag and labeled and dated to know when it was opened, and should be thrown out. -The bag of cabbage should have been labeled and dated for the same reason. -She did not know the plastic storage drawers had spillage and debris. -She expected the dietary staff to follow the weekly cleaning schedule.	D 283		
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: Based on observations, record reviews, and interviews, the facility failed to ensure that therapeutic diets were served as ordered for 1 of 1 sampled resident (#2), who had an order for a mechanical soft diet. The findings are: Observation of the kitchen on 03/25/26 at 9:30am revealed: -A menu was lying on a table inside the kitchen. -The week was documented as week 4. -The menu for lunch was listed as baked pollock, sweet potato wedges, creamy coleslaw, dinner roll, and a hello dolly bar.	D 310		

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D 310	Continued From page 13 -The menu for dinner was listed as saltine crackers, corn chowder, a burger, garden salad with dressing, and a fruit cup. -There was no therapeutic diet menu visually seen in the food preparation area. Observation of the kitchen on 03/26/26 at 8:30am revealed: -A menu was lying on the food preparation table. -The week was documented as week 4. -The menu for breakfast was listed as oatmeal, a fresh whole apple, scrambled eggs with onion, and wheat toast. -There was no therapeutic diet menu visually seen in the food preparation area. Review of the therapeutic diet menu provided by the Administrator on 03/26/26 at 9:22am revealed: -For a mechanical soft diet, creamy coleslaw should be substituted with cooled cauliflower. -For a mechanical soft diet, a garden salad should be substituted with a cooked vegetable blend. -For a mechanical soft diet, a whole apple should be substituted with apple sauce. Review of Resident #2's current FL2 dated 01/12/26 revealed: -Diagnoses included Alzheimer's disease, intellectual disability, peripheral vascular disease, and hypertensive heart disease. -There was an order for a mechanical soft diet, which was described as this diet modification was ordered for a resident who had difficulty chewing, and the entire meal was marked. Review of Resident #2's primary care provider's (PCP) after-visit summary dated 09/22/25 revealed:	D 310		

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D 310	Continued From page 14 -Resident #2 had intermittent swallowing problems. -Resident #2 had difficulty chewing, with no teeth or dentures, and was mostly able to masticate with her gums. -When asked, Resident #2 said she had "a little bit" of swallowing problems. -Resident #2 packed her mouth too full of food to swallow it safely. Review of Resident #2's Licensed Health Professional Services (LHPS) nurse's assessment dated 12/05/25 revealed: -Diet continued to be a mechanical soft. -Resident #2 could feed herself but needed monitoring for safety. Observation of the lunch meal on 03/25/26 at 12:41pm revealed: -Resident #2 was served cut-up fish sticks, cut-up sweet potato, and coleslaw. -Resident #2 ate 25% of her meal. -She was not served the dinner roll. -She coughed once during her meal. Observation of the dinner meal on 03/25/26 at 5:00pm revealed: -Resident #2 was served a bowl of corn chowder, a cut-up burger, and a garden salad with dressing. -She was not served the dinner roll. Observation of the breakfast meal on 03/26/26 at 8:02am revealed: -Resident #2 was served scrambled eggs with onions and a chopped apple. -She was not served wheat toast. -Resident #2 ate 25% of her meal. -Her bowl of chopped apples had multiple pieces that appeared to have been gnawed on.	D 310		

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-She put a piece of apple in her mouth, tried to chew it, removed the piece of apple, and returned it to the bowl.
-She coughed once during her meal.

Interview with the cook on 03/25/26 at 5:22pm revealed he prepared the garden salad by cutting up the lettuce, chopping the onions and tomatoes, and adding a lot of salad dressing.

Interview with the cook on 03/25/26 at 8:55am revealed:
-Resident #2 could not eat bread; he did not know why.
-He chopped Resident #2's food up because she stuffed her mouth with food and sometimes choked.
-He only used the menu he showed me, which was the regular menu.
-If a resident had any special needs, it was written on the whiteboard in the kitchen.

Observation of the whiteboard on 03/25/26 at 9:25am revealed that Resident #2 was listed as having chopped meals.

Interview with a medication aide (MA) on 03/26/25 at 9:08am revealed:
-Resident #2 was served a chopped diet.
-Resident #2 could not have anything hard at all because she got choked a lot.
-Resident #2 sometimes choked because she could not chew her food.
-She had seen Resident #2 still chewing on food after a meal, and she would tell the resident to swallow the food or spit it out.

Interview with the Resident Care Coordinator (RCC) on 03/26/26 at 9:11am revealed:
-Resident #2 had an order for a mechanical soft

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diet.
-When she was in the dining room, she made sure Resident #2's meal was chopped.
-Resident #2 ate fast and held food in her mouth.
-Resident #2 was seen by speech therapy in 2025.
-Resident #2 had to be reminded to slow down when she was eating.

Interview with Resident #2 on 03/26/25 at 9:49am revealed:
-She did not have teeth.
-Sometimes she had a hard time chewing food up.
-Examples of food she had a hard time chewing were strawberries, hot dogs, and apples.
-She coughed when she ate because she could not chew some food up good and would try to swallow it.

Interview with the Dietary Manager (DM) on 03/26/25 at 10:05am revealed:
-Resident #2 was served pureed and chopped foods.
-She made sure vegetables were cooked all the way through.
-Meats like ham were chopped up fine.
-She thought coleslaw and a salad could be served if it was diced with a lot of dressing to make it easier to swallow.
-She thought an apple could be served if the apple was cut up fine.
-She had not had to use the therapeutic menu for guidance.
-She tried to make sure the residents got what they wanted/needed without limiting them.
-She thought a mechanical soft diet was mostly pureed.

Interview with the Administrator on 03/26/26 at

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D 310	Continued From page 17 10:19am revealed: -The facility had therapeutic menus for staff to use. -Resident #2 had an order for a mechanical soft diet. -She did not observe every meal, but the dietary staff had the proper tools to ensure Resident #2's diet was served correctly. Attempted telephone interview with Resident #2's PCP on 03/25/26 at 3:57pm was unsuccessful. Attempted telephone interview with the LHPS nurse on 03/26/26 at 9:54am was unsuccessful. Attempted telephone interview with a second cook on 03/26/26 at 10:42am was unsuccessful.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the rights of the residents were maintained, including a resident (#4) who was touched inappropriately by a male resident. The findings are: Review of Resident #4's current FL-2 dated 02/09/26 revealed: -Diagnoses included dementia, Alzheimer's	D 338		

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disease, and major depressive disorder.
-She was constantly confused.
-She wandered.
-She was ambulatory.

Review of Resident #4's care plan dated 02/09/26 revealed:
-She ambulated without difficulty.
-She was always disoriented.
-She had a significant loss of memory.

Observation of Resident #4 on 03/25/26 from 10:00am to 12:30pm and from 2:00pm to 4:00pm revealed Resident #4 was seen sitting in the day room, living room, and dining room throughout the day.

Review of Resident #4's electronic progress notes dated 03/04/26 at 12:24am revealed:
-A male resident was found in Resident #4's bedroom touching her inappropriately.
-The male resident was removed from Resident #4's room and redirected.

Review of Resident #4's incident/accident reports revealed there was no incident/accident report regarding Resident #4 being touched inappropriately by a male resident.

Review of Resident #4's Mental Health Provider's (MHP) psychiatry progress note dated 03/13/26 revealed there was no documentation related to the incident on 03/04/26 of a male resident inappropriately touching Resident #4.

Interview with Resident #4's MHP on 03/26/25 at 1:51pm revealed:
-Her last visit to the facility was 03/13/26.
-She was made aware of Resident #1 touching a female resident on 03/13/26, during her on site

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visit.
-She would have instructed the staff to keep Resident #1 away from the female resident had she been notified of the incident the same day it occurred.
-She expected to be notified of an incident of inappropriate behavior on the same day the incident occurred.
-She instructed the staff on 03/13/26 to keep the male resident away from Resident #4.

Interview with the Resident Care Coordinator (RCC) on 03/26/26 at 9:18am revealed:
-The staff were instructed to keep Resident #4 and the male resident apart by increasing the supervision on all shifts.
-Resident #4 sat in the day room or the living room during the day, where she could be easily monitored.
-There had been no other incidents that the staff was aware of.

Interview with the Administrator on 03/26/25 at 9:35am revealed:
-Resident #4 and the male resident's supervision were increased.
-The staff were instructed to keep the two residents apart.
-The MHP should be notified immediately of incidents of inappropriate touching.

Attempted telephone interview with the Adult Home Supervisor (AHS) on 03/25/26 at 12:13pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable.

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D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 2 of 3 sampled residents (#2, #3) including an antiviral medication (#2) and a laxative (#3). The findings are: 1. Review of Resident #2's current FL2 dated 01/10/26 revealed: -Diagnoses included Alzheimer's disease, intellectual disability, peripheral vascular disease, and hypertensive heart disease. -There was documentation to see attached for medications. -The attached physician's orders form were current as of 12/31/25. -There was an order for oseltamivir (an antiviral medication used to treat and prevent influenza)	D 344		

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D 344	Continued From page 21 75mg take one capsule twice daily for 5 days. Review of Resident #2's primary care provider (PCP) after-visit summary dated 12/29/25 revealed and order for oseltamivir 75mg, one capsule twice daily for 5 days. Review of Resident #2's January 2025 electronic medication administration record (eMAR) revealed: -There was an entry for oseltamivir 75mg take one capsule twice a day for 5 days, with a start date of 12/29/25 and a stop date of 01/03/26, scheduled at 8:00am and 8:00pm. -Oseltamivir was documented as administered twice daily at 8:00am and 8:00pm on 01/01/26-01/03/26 and was then discontinued. -There was no second entry for oseltamivir 75mg dated 01/12/26 (the date the physician's orders were signed). Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/25/26 at 3:43pm revealed: -The pharmacy received an order on 12/29/25 for Resident #2's oseltamivir 75mg. -Ten capsules were dispensed on 12/29/25 for a five-day supply. -The pharmacy received a copy of Resident #2's signed physician's orders dated 01//12/26. -Oseltamivir was not dispensed because they assumed that since they had just sent out a 5-day supply, it was not needed. -Oseltamivir would only be reordered if it were a severe case of the flu. -Best practice would be to reach out and clarify if the order was signed by accident. Interview with a medication aide (MA) on 03/25/26 at 4:00pm revealed:	D 344		

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-The PCP was at the facility on Mondays and made rounds with the Resident Care Coordinator (RCC).
-Any changes would be reported to the RCC.
-The RCC would then tell the MAs what the changes were.
-She did not usually see the FL2s or signed physician's order.
-She did not recall if Resident #2 was on the oseltamivir once or twice.

Interview with the RCC on 03/25/26 at 4:14pm revealed:
-She completed the FL2s, care plans, and printed off the physician's orders all at the same time for the PCP to review and sign.
-She printed Resident #2's FL2, care plan and physician's orders on 12/31/25.
-Once the FL2 and the physician's orders were signed, she sent those to the pharmacy because they were considered new orders.
-She looked to make sure everything on the signed physicians' orders matched the eMAR.
-She missed seeing that the order for Resident #2's oseltamivir was on the physicians' orders when the PCP signed the orders on 01/12/26.

Interview with the Administrator on 03/26/25 at 4:40pm revealed:
-The RCC was responsible for completing the FL2 and physicians' orders.
-Resident #2's order for oseltamivir should not have been on the physician's orders when signed by the PCP if it was not a current order.
-The RCC should have seen the order for the oseltamivir and had it clarified.

Attempted telephone interview with Resident #2's PCP on 03/25/26 at 3:57pm was unsuccessful.

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D 344	Continued From page 23 2. Review of Resident #3's current FL2 dated 01/21/26 revealed: -Diagnoses included hypertension, heart failure, chronic kidney disease, atrial fibrillation and dementia. -There was an order for MiraLAX powder (a laxative medication used to treat constipation) 15 grams (gm)/scoop take daily with 4-8 ounces (oz) of fluid. Review of Resident #3's electronic medication administration record (eMAR) for January 2026 from 01/21/26 through 01/31/26 revealed: -There was an entry for MiraLAX 15gm daily scheduled at 8:00am. -There was documentation MiraLAX was administered daily from 01/21/26 through 01/31/26. Review of Resident #3's eMAR for February 2026 revealed: -There was an entry for MiraLAX 15mg daily scheduled at 8:00am. -There was documentation Resident #3 was administered MiraLAX daily from 02/01/26 through 02/07/26 until the order was discontinued from the eMAR on 02/07/26. Review of Resident #3's eMAR for March 2026 revealed there was no entry for MiraLAX or documentation MiraLAX was administered. Observation of medications on hand for Resident #3 on 03/25/26 at 4:10pm revealed: -There was one 17.9oz bottle of MiraLAX powder with a dispensed date of 01/21/26. -The bottle was almost full. Interview with the Resident Care Coordinator (RCC) on 03/25/26 at 11:54am revealed:	D 344		

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D 344	Continued From page 24 -There was no order to discontinue Resident #3's MiraLAX. -It was an error on her part that the MiraLAX order "fell off" the eMAR and she did not catch it. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/25/26 at 2:47pm revealed: -Resident #3 did not have an active order for MiraLAX. -It appeared the MiraLAX order was discontinued on 03/12/26. -He did not know why the order was removed from the eMAR on 02/07/26. -There was no physician's order to discontinue Resident #3's MiraLAX. Telephone interview with a representative from Resident #3's primary care provider's (PCP) office on 03/25/26 at 2:17pm revealed: -Resident #3 had an order for MiraLAX dated 01/28/26. -There was no current order for MiraLAX on file for Resident #3. -She did not see an order to discontinue the MiraLAX. -She did not know why Resident #3's MiraLAX was discontinued. -Nobody from the facility had contacted the PCP's office to clarify Resident #3's MiraLAX order. Second telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/25/26 at 3:52pm revealed: -Resident #3's orders were confusing since sometimes the orders were received under 2 different first names for the resident. -Resident #3 had two different accounts profiled at the pharmacy. -MiraLAX was last dispensed for Resident #3 on	D 344		

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10/28/25 under one of her profiles, and 01/21/26 under her other profile.
-There was no order to discontinue MiraLAX under either of Resident #3's profiles.

Interview with the medication aide (MA) on 03/25/26 at 4:10pm revealed:
-When new medication orders were received, the RCC was responsible for notifying the MAs.
-The RCC checked the residents' medication orders and would instruct the MAs to pull medications that were discontinued off of the medication cart.
-If a resident returned from the hospital with new orders, the MA was responsible for faxing the order to the pharmacy.
-The RCC was responsible for faxing updated FL2s and signed physician order sheets to the pharmacy.
-When Resident #3 returned to the facility from being at the rehabilitation facility in January 2026, she did receive MiraLAX.
-She thought Resident #3 was still ordered and receiving MiraLAX every morning.
-Resident #3 was ordered MiraLAX because she was taking a medication that could cause constipation, but the MiraLAX had been discontinued a couple of times due to Resident #3 having loose stools.
-She had not noticed that the MiraLAX was removed from the eMAR in February 2026.
-If a medication did not "pop up" on the eMAR as being due for administration, she did not administer it.

Interview with a second MA on 03/26/26 at 08:56am revealed:
-She noticed Resident #3's MiraLAX was not on the eMAR.
-The third shift MAs completed medication cart

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D 344	Continued From page 26	D 344		

audits but mostly checked for expired medications or medications that needed to be refilled; they did not compare the medications on the cart with current medication orders or orders on the eMAR.
-Resident #3 had not complained of constipation.

Interview with the RCC at on 03/26/26 revealed:
-There were no month-to-month eMAR comparison audits to catch if a medication was erroneously removed from the eMAR.
-She had not been told by the MAs that Resident #3's MiraLAX order was not on eMAR but that there was a bottle of MiraLAX on the medication cart; if they had notified her she would have clarified the order with Resident #3's PCP.
-Resident #3 had not been constipated.
-Resident #3 was incontinent of bowel and bladder and had had loose stools secondary to antibiotics recently.

Interviewed the Administrator on 03/26/26 at 9:05am revealed:
-The RCC was responsible for catching medication changes or clarifying any medication orders.
-The RCC sent in all new orders to the pharmacy, the pharmacy entered orders on the eMAR, then they needed to be approved by the RCC prior to the MAs documenting the medication as administered.
-If the pharmacy discontinued a medication order from the eMAR, the order just "fell off" and did not require approval from the RCC.

Based on observations and record reviews, Resident #3 was not interviewable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019022	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNMORE SENIOR LIVING OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

(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 378	Continued From page 27	D 378		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication cart was locked and the medication room door was closed and locked when not under the direct supervision of a medication aide (MA). The findings are: Observation of the medication room on 03/25/26 at 8:30am revealed: -The medication room door was opened with no direct supervision of the MA. -The unlocked medication cart was in the medication room. -The medication cart drawers could be opened, with multiple punch cards accessible to the surveyor. -There were liquid medications, inhalers, and eye drops accessible to the surveyor in the medication cart. -There was Maalox (used to treat heartburn or indigestion) in an unlocked cabinet in the medication room. -There was insulin pens in the unlocked	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019022	A. BUILDING: _____ B. WING _____	03/26/2026

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DUNMORE SENIOR LIVING OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

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D 378	Continued From page 28 refrigerator in the medication room. Observation of the medication room on 03/25/26 at 8:34am revealed the medication room was locked. Interview with the MA on 03/26/26 at 8:02am revealed: -She passed medications the morning of 03/25/26. -She placed the medication cart in the medication room but failed to lock the medication cart. -She closed the medication room door, which automatically locked. -The personal care aide (PCA) had access to the medication room to obtain supplies. -Management also had access to the medication room. -She should have locked the medication cart even when the medication cart was in the medication room. Interview with the Resident Care Coordinator (RCC) on 03/26/25 at 9:30am revealed: -She unlocked the medication room door to retrieve the bathroom key and left the door opened. -She was taking the bathroom key back to the medication room, when the surveyors arrived at the front door. -She opened the front door to let the surveyors into the facility and took the surveyors to the Administrator's office. -She should have closed the medication room door when she retrieved the bathroom key. -Residents could have wandered into the medication room and gotten some medications. Interview with the Administrator on 03/26/26 at 9:36am revealed:	D 378		

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 378	Continued From page 29 -She expected the medication cart and the medication room to be locked when not under the direct supervision of the MA or the RCC. -She was concerned that a resident could walk in the medication room and remove medications and/or take medications. -A visitor could walk in the medication room and take medications. -The facility had residents with diagnoses of dementia and Alzheimer's disease, and residents that wandered in the facility.	D 378		