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	HAL032132	A. BUILDING: _____ B. WING _____	05/01/2026

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CAROLINA RESERVE OF DURHAM	4523 HOPE VALLEY ROAD DURHAM, NC 27707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 04/29/26 to 05/01/26.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 6 of 6 exterior exit doors accessible to the residents were equipped with a continuous sounding device that was audible throughout the facility when the door was opened and accessible to three residents (#3, #7, #8) residing in the facility who were known to be intermittently disoriented.	D 067		

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D 067	Continued From page 1 The findings are: Review of the facility's current license, effective 01/01/26, revealed the facility was licensed for 60 beds. Review of the facility's census on 04/29/26 revealed 44 residents: 25 in the Assisted Living (AL) and 19 in a secured unit. Observation of the facility's side exit door between residents' rooms 114 and 112 on 04/28/26 at 9:30am revealed: -The door was unlocked and there was no audible sound heard when the door opened. -No staff responded when the door was opened. -The alarm unit switch was turned to the "OFF" (disarmed) position. -The Maintenance Director observed that the door opened without sound and switched the unit to the "ON" position. Observation of the activities room on 04/29/26 at 10:40am revealed: -The doors from the hallway into the room were propped opened and did not have a locking mechanism. -There was an exit door in the activities room leading to the outside driveway. -There was a large red alarm on the door that read stop, alarm would sound, emergency use only. -The alarm was turned to the "on" position. -When the door was opened, the alarm was audible for 31 seconds and then it stopped. -There was a second alarm device mounted to the exit door with one component on the door and the corresponding component on the door frame. -There was no audible sound from the second	D 067		

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alarm device when the door was opened.

Interview with the facility's Corporate Clinical Nurse Specialist on 04/29/26 at 10:41am revealed that she would need a key to turn off the alarm; the alarm stopped before she returned with a key.

Interview with the Maintenance Director on 04/29/26 at 10:40am revealed some staff members had keys to open the doors, but did not relock them which would reactivate the alarm.

Second observation of the exit door in the activities room on 04/29/26 from 11:03am-11:06am revealed:
-The red alarm was turned to the "off" position so the second alarm could be tested.
-The door was opened, and no audible alarm was heard from the second alarm device.
-No staff members responded to the door being opened.

Interview with a medication aide (MA) on 04/29/26 at 11:10am revealed:
-The door alarm only alerted her telephone if the red alarm box was turned on.
-She could not hear the red alarm if it was activated in one hall and she was in the furthest hall, providing resident care.

Observation of the MA's telephone on 04/29/26 at 11:11am revealed when the door was opened while the MA was in the room, the alarm did not activate her telephone.

Observation of the facility's exit doors on 04/30/26 at various times between 8:40am-10:08am revealed:
-The staff telephones identified each exit door by

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its proximity to the closest resident room number.
-There were two exit doors on the 100 hall, identified as the 113 exit door, and the 114 exit door.
-There were two exit doors on the 200 hall, identified as the 209 exit door, and the 212 exit door.
-There was an exit door in the dining room with no alarms on the door.
-There were two entrance doors from the hallway into the dining room without locks.
-At 8:40am, the 113 exit door's red alarm was turned to the "off" position.
-At 8:41am, the 212 exit door's red alarm was turned to the "on" position, but the secondary alarm's two components were not lined up to activate when the door was opened.
-At 9:03am, the Maintenance Director turned the red alarm to the off position on exit door 209 and opened the door; no audible alarm was heard.
-A personal care aide (PCA) responded to the door and showed the surveyor her telephone, which showed that exit door 209 was opened; she cleared the door alert from her telephone.
-At 9:08am, there was a faint continuous beep from the red alarm on the 114 exit door.
-The Maintenance Director had not received notification on his telephone the exit door had been opened.
-At 9:15am, a PCA showed her phone had pinged; she stated she could not hear the faint continuous beeping from the main alarm.
-At 9:57am, the 114 exit door was opened, and no audible alarm was heard.
-The Maintenance Director's telephone did not have an audible alert when the door was opened.
-At 10:00am, the Maintenance Director opened the door a second time, and an audible one-time chime was heard on a staff member's telephone in the hallway; the staff member did not respond

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to the opened door.
-The staff member's telephone showed the door opened was 209, not 114.
-Exit door 114 was opened multiple times, and the staff member's telephone displayed exit door 209 as the door that was opened.
-At 10:08am, the 113 exit door was opened, and no audible alarm was heard.
-The Maintenance Director's telephone did not have an audible alert when the door was opened, but a PCA did respond to the door.

Interview with the Maintenance Director on 04/29/26 at 9:30am revealed:
-The faint beep was because the batteries were low in the main alarm.
-His phone was not pinging, which could be due to technology failing.
-He thought the staff members were clearing the door alarms and not responding because they knew the door alarms were being tested.

Interview with the Maintenance Director on 04/30/26 at 10:08am revealed he contacted the door alarm support team, and there were two doors identified as exit door 209, and it had been corrected.

Interview with a PCA on 04/30/26 at 10:01am revealed:
-She received a notification on her telephone that exit door 113 was opened.
-She did not clear the alarm because she did not know what was going on with the testing of the door alarms.
-Whoever was assigned to the hallway where the exit door was activated, was responsible for checking the door.
-If the exit door alarm was not cleared after one minute, she would check the exit door herself.

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D 067	Continued From page 5 Interview with a MA on 04/30/26 at 11:49am revealed: -Her telephone was not working at that time, so she was not alerted to any of the exit doors being opened. -When her telephone alerted to an exit door being opened, she would respond to the door and make sure no one had left the facility. -The Maintenance Director and the MAs were the only staff members who had keys to cut the red alarms on and off. -The Maintenance Director checked the exit doors every day to make sure the alarms were turned on. -She did not check the exit doors to make sure the alarms were turned on. -She did not know why the 113 exit door was turned off today, 04/30/26, or who would have turned it off. -When the exit door alarm went off, if she did not see who exited the facility, she would make sure every resident was in the facility. Interview with the Corporate Clinical Nurse Specialist on 04/30/26 at 5:29pm revealed: -Door alarms were to alert staff members when someone had exited the facility. -The secondary alarm (the alarm device mounted with one component on the door and the corresponding component on the door frame) was the primary alarm system used, and the red alarms were the backup. -When the secondary alarm was activated, an alert was sent to all of the caregiver's telephones. -The alert included the location of the door alarm, and staff had to respond to the door that was opened to clear the alarm. -Her biggest concern was that if the alarm system was not working correctly, there were some	D 067		

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residents who were intermittently disoriented, and if the staff members were busy providing care, they may not know in a timely manner that a resident had left the facility.

Interview with the Maintenance Director on 05/01/26 at 10:05am revealed:
-Staff might disarm the main alarm when going out the door to take out trash and leave it in the "off" position, disarmed.
-There was a secondary system sensor in place on all doors which pinged all staff phones when a door was opened but was not audible throughout the facility.
-The secondary alarm system could be cleared from the staff phones when they were within proximity to the sensor that pinged.
-He did a walk through each morning to check all alarms and doors unless there was some other priority.

Interview with the Regional Director of Clinical Services on 05/01/26 at 3:32pm revealed:
-Door alarms were installed to let staff know if anyone was exiting the facility.
-Maintenance staff was responsible for ensuring the door alarms were working.
-The doors were supposed to be armed for residents' safety.
-Her concerns would be that residents could exit out of unlocked, unarmed doors.
-She was concerned that staff had not been educated about turning the alarm on.
-She was concerned that if staff did not have their phones on them, they would miss a door sensor ping.
-If a door alarm was turned off, it would not be effective to protect the residents.

Telephone interview with the Regional Director of

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D 067	Continued From page 7 Operations on 05/01/26 at 3:59pm revealed: -The door alarms were for the safety of the residents who were entering and exiting the facility. -She was not aware that there were doors with no alarms and doors with alarms that had been turned off. -She was concerned that the alarms were turned off and staff needed to be educated. -The alarm should always be on for notification of a resident exiting or entering. 1. Review of Resident #7's current FL2 dated 12/22/25 revealed: -Diagnoses included neurocognitive disorder with Lewy body dementia, insomnia, and muscle weakness. -She was semi-ambulatory. Review of Resident #7's care plan dated 02/05/26 revealed: -Resident #7 was sometimes disoriented. -She was forgetful and needed reminders. -She needed supervision from staff for bathing, dressing, and toileting. -She was a wandering risk, and staff should provide supervision and redirection to avoid and prevent wandering episodes. Interview with a medication aide (MA) on 04/30/26 at 11:49am revealed: -Resident #7 never knew where she was. -Staff on third shift had reported that Resident #7 was up all night, wandering around inside the facility. -Resident #7 had never exited the facility that she knew of. Telephone interview with another MA on 04/30/26 at 9:32pm revealed:	D 067		

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D 067	Continued From page 8 -Resident #7's memory was "really bad". -Resident #7 had Lewy body dementia. -Resident #7 stayed up all night; she did not sleep at all. -Resident #7 always thought she had somewhere to go or something to do. Interview with the Resident Care Coordinator (RCC) on 04/30/26 at 5:18pm revealed Resident #7 did not need supervision to be outside. Telephone interview with Resident #7's primary care provider (PCP) on 05/01/26 at 12:20pm revealed: -Resident #7 had both Alzheimer's disease and Lewy body dementia that was fast in aggression. -Resident #7 had unpredictable episodes of disorientation. -Resident #7 did not need to be in a special care unit (SCU), but having exit doors without alarms could be dangerous. -Resident #7 could be disoriented and go outside and not be able to find her way back inside, and could have a fall. -Resident #7 could not be outside without supervision. Attempted interview with the facility's Director of Clinical Services on 04/30/26 at 4:00pm was unsuccessful. Attempted interview with the Interim Administrator on 04/30/26 at 4:00pm was unsuccessful. 2. Review of Resident #3's current FL2 dated 04/03/26 revealed: -Diagnoses included chronic fatigue syndrome, contracture, and dementia. -He was intermittently disoriented. -He was ambulatory.	D 067		

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D 067	Continued From page 9 Review of Resident #3's care plan dated 04/03/26 revealed: -He was sometimes disoriented. -His memory was forgetful and needed reminders. -He was ambulatory with the use of a walker. -He was independent with transfers, and required supervision from staff with ambulation. Interview with Resident #3's family member on 04/30/26 at 5:05pm revealed: -Resident #3 had a recent decline in the previous couple of days and was requiring more assistance with mobility. -Resident #3 required supervision to go outside. Telephone interview with a medication aide (MA) on 04/30/26 at 9:32pm revealed: -Resident #3 had sundowning "really bad". -Up until recently, Resident #3 was ambulatory and independent with his care. -Resident #3 had a fall and was now combative at times. Interview with the Resident Care Coordinator (RCC) on 04/30/26 at 5:18pm revealed: -Resident #3 was walking with a walker but was placed in a wheelchair for safety after a recent fall. -He could get up and walk but did not have a steady gait and could have a fall, and would need supervision to be outside. Attempted interview with the facility's Director of Clinical Services on 04/30/26 at 4:00pm was unsuccessful. Attempted interview with the Interim Administrator on 04/30/26 at 4:00pm was unsuccessful.	D 067		

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3. Review of Resident #8's current FL2 dated 12/15/25 revealed:
-Diagnoses included chronic pancreatitis and muscle weakness.
-She was semi-ambulatory.

Review of Resident #8's Resident Register revealed:
-She was admitted to the facility on 12/16/25.
-Her memory was documented as forgetful, and she needed reminders.

Review of Resident #8's care plan dated 01/26/26 revealed:
-Resident #8 was sometimes disoriented.
-She was forgetful and needed reminders.
-She needed limited assistance from staff with ambulation, toileting, and transferring.
-She needed extensive assistance from staff for bathing, dressing, and grooming.

Interview with a medication aide (MA) on 04/30/26 at 11:49am revealed:
-Resident #8 would need supervision if she were outside to ensure the resident did not walk off.
-Resident #8 was very confused and never knew where her room was.

Telephone interview with another MA on 04/30/26 at 9:32pm revealed:
-Resident #8 did not get up during the night.
-She was confused during the day and was forgetful.
-Resident #8 came in and out of her room all day long.
-Resident #8 used a walker but usually pushed a wheelchair instead.

Interview with the Resident Care Coordinator

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(RCC) on 04/30/26 at 5:18pm revealed Resident #8 did not need supervision to be outside.

Telephone interview with Resident #8's primary care provider (PCP) on 04/30/26 at 4:51pm revealed:
-Resident #8 had vascular dementia.
-Resident #8 was in an Assisted Living (AL) facility because she needed supervision to keep her safe.
-Resident #8 had not exhibited any signs of wandering or wandering at night.
-Resident #8's dementia was slowly progressing.
-Resident #8 was safe as long as the doors were alarmed.

Telephone interview with Resident #8's family member on 05/01/26 at 12:29pm revealed:
-Resident #8 was an "inside person" and never went outside.
-If Resident #8 went outside, she would need supervision.
-Resident #8 was not a wanderer.
-She was not "totally out of it".

Based on interviews and reviews, it was determined Resident #8 was not interviewable.

Attempted interview with the facility's Director of Clinical Services on 04/30/26 at 4:00pm was unsuccessful.

Attempted interview with the Interim Administrator on 04/30/26 at 4:00pm was unsuccessful.

_____

The facility failed to ensure that all 6 exterior exit doors accessible to residents were equipped with a continuous, audible alarm system that would alert staff whenever activated, for three residents who were known to be intermittently disoriented

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D 067	Continued From page 12 and/or at risk of wandering. The facility's 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 04/30/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 15, 2026.	D 067		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A 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 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 mattress and boxspring that were leaning up against a wall, a metal bed frame laying on the floor, and a bed with an attached	D 079		

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D 079	Continued From page 13 metal frame that was tipped over in an empty resident room in the special care unit (SCU). The findings are: Observation of resident room #316 in the SCU on 04/29/26 at 12:09pm revealed: -The door to room #316 was wide open. -The bed mattress was leaning up against the wall. -The bed boxspring was leaning up against the wall next to the mattress. -The metal bed frame was taken apart and laying on the floor in front of the mattress and boxspring. -The metal frame had sharp metal edges. -There was a metal frame with a mattress attached tipped over with the metal legs sticking out with sharp edges. -There was no other furniture in the room. Observation of the SCU at various times on 04/29/26-05/01/26 revealed: -There were two residents that wandered throughout the SCU. -The two residents would go into other residents' rooms throughout the day. Observation of a resident on 05/01/26 at 11:56am revealed: -He was standing outside of resident room #316 looking inside. -He took 4 steps inside resident room #316. -He stood there for less than 1 minute. -The resident then turned around, exited resident room #316 and walked down the hall. Interview with a personal care aide (PCA) on 05/01/26 at 11:08am revealed: -She had seen the mattress, boxspring, bed	D 079		

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	HAL032132	A. BUILDING: _____ B. WING _____	05/01/2026

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frame in resident room #316.
-She was unsure how long the items had been in the room.
-Sometimes the residents would go into resident room #316.

Interview with the Resident Care Coordinator (RCC) on 05/01/26 at 1:12pm revealed:
-The furniture had been in resident room #316 for at least a week.
-She had asked the staff to keep the door closed and locked on multiple occasions.
-She was aware that there were a couple residents in the SCU that wandered into rooms throughout the day.
-She was concerned that a resident could fall and get hurt.
-She could not recall if she let the Maintenance Director know that the furniture was in resident room #316.

Interview with the Regional Director of Clinical Services on 05/01/26 at 2:56pm revealed:
-She was not aware that resident room #316 had furniture leaning against the wall or a metal bed frame on the floor.
-She was concerned that a resident could trip and fall, especially on the metal bed frame.
-She expected staff to keep the door closed and locked.

Interview with the Maintenance Director on 05/01/26 at 4:00m revealed:
-He did not know why the furniture was left in the room but thought it could be the furniture was property of the facility and not the previous resident that had stayed in resident room #316.
-The residents' doors in the SCU did not lock.
-He was not aware of the furniture in resident room #316, or he would have removed it.

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D 079	Continued From page 15 -He did not do resident room checks. Attempted telephone interview with the DCS on 04/30/26 at 4:00pm was unsuccessful. Attempted interview with the Interim Administrator on 04/30/26 at 4:00pm was unsuccessful.	D 079		
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to maintain 2 of 7 exit doors accessible to residents in the assisted living (AL) area in operable condition for use by residents and/or staff during an emergency. The findings are: Observation of the facility's side exit door between resident room 111 and resident room 113 on 04/29/26 at 9:34am revealed that the door could not be opened.	D 105		

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D 105	Continued From page 16 Observation of the facility on 04/30/26 between 8:44am-9:00am revealed: -There was a long hallway to the left of the front entrance. -At the end of the hallway, the hallway branched left or right, and there was an exit door at each end of the hallway. -The emergency exit door in the left hallway, exit door 113, would not open when attempted multiple times by the surveyor. -There were 4 residents' rooms that would use exit door 113 as their primary exit from the facility in the event of an emergency, and three of the six residents used an assistive device for ambulation. -There was a long hallway to the right of the front entrance. -At the end of the hallway, the hallway branched left or right, and there was an exit door at each end of the hallway. -The emergency exit door in the right hallway, exit door 212, would not open when attempted multiple times by the surveyor. -There were 4 residents' rooms that would use exit door 212 as their primary exit from the facility in the event of an emergency. -There was one resident who was ambulatory and one resident who was bed/chair confined who currently resided in rooms in this hallway. Observation of the exit door 212 on 04/30/26 at 8:48am revealed: -The Maintenance Director had to use his body to force the door to open. -Once the door was opened, it would not close back. Interview with the Maintenance Director on 04/30/26 at 8:55am revealed: -The door had been hard to open since he started	D 105		

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in May 2024 and had only "gotten worse".
-The hinges are misaligned, so you had to force the door.
-It was one of the doors that needed working on.

Interview with the resident who resided in resident room 210 on 04/30/26 at 8:48am revealed:
-She wanted to know if there was a problem with the door.
-She wanted to be sure if there was an emergency like a fire that she would be able to exit the facility out of "that door".

Observation of the exit door 212 on 05/01/26 at 8:26am revealed:
-The Maintenance Director had to use his body to force the door to open.
-Once the door was opened, it would not close back.

Interview with a medication aide (MA) on 05/01/26 at 10:05am revealed:
-She did not know the exit door 212 was stuck until 04/30/26.
-She had never opened the door; it would only be used in an emergency.
-The door needed to be operable because there was a resident who was confined to the bed, who would need to exit that door in an emergency.
-The other residents could be helped to get out of a window to exit the facility during an emergency if the door did not open.

Interview with a second MA on 05/01/26 at 10:55am revealed that she had never tried to open the exit door 212.

Interview with a personal care aide (PCA) on 05/01/26 at 10:55am revealed that she had only worked at the facility for three months and had

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never used an emergency exit door.

Interview with the Regional Director of Clinical Services on 05/01/26 at 3:32pm revealed:
-She expected the exit doors to be checked monthly.
-If there was an issue identified with an exit door, the Maintenance Director should be notified, and he would let the Executive Director know.
-She expected the exit doors to function so residents could exit through the closest exit door.

Interview with the Maintenance Director on 05/01/26 at 8:26am and 10:05am revealed:
-The exit door 212 was hard to open.
-He did not know if a resident would be able to open the door to exit the facility.
-The last time he opened exit door 113, the door was difficult to open.
-He did not recall the last time he had opened exit door 113, but it had been about 45 days ago.
-Prior to that, the door was dragging but would open and close.
-He thought a resident could open the exit doors even though they were dragging.
-He had told the Executive Director (ED) and a corporate representative that when he started in 2024, there was an issue with the two exit doors.
-The doors were not replaced because it was a budget issue at the time.
-Any expense over five hundred dollars, he had to get the ED and corporate regional representative to approve the purchase order.
-For the past 45 days, all the staff members knew the exit door 212 was hard to open and close.
-The last 45 days, the exit door 113 was getting harder to open, but you did not have to use force to open it.

Telephone interview with the facility's corporate

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D 105	Continued From page 19 Maintenance Director on 05/01/26 at 11:15am revealed: -Exit doors should be checked monthly to ensure the doors were operational. -He did not know until today, 05/01/26, that there was a problem with exit door 212. -The doors had rusted and swelled, causing difficulty in opening. -He did not know that the exit door 113, was also difficult to open. -A vendor had already been contacted today, 05/01/26, to replace exit door 212, but he would call to order an additional door to replace the 113 door. Telephone interview with the Regional Director of Operations on 05/01/26 at 3:59pm revealed: -Emergency exit doors should be operational to have egress. -Residents needed to be able to evacuate if there was an emergency. Attempted interview with the facility's Director of Clinical Services on 04/30/26 at 4:00pm was unsuccessful. Attempted interview with the Interim Administrator on 04/30/26 at 4:00pm was unsuccessful. _____ The facility failed to ensure that 2 exit doors were maintained in proper working order and were readily operable for residents to safely exit the facility during an emergency. The facility's failure was detrimental to the health, safety, and welfare of the residents, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/01/26.	D 105		

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D 105	Continued From page 20 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 15, 2026.	D 105		
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of	D 253		

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D 253	Continued From page 21 daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10)skin integrity; (11)memory, orientation and cognition; (12)vision and hearing; (13)speech and communication; (14)assistive devices needed; and (15)a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement a care	D 253		

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plan within 30 days following admission for 1 of 5 sample residents (#1).

The findings are:

Review of Resident #1's current FL2 dated 11/25/25 revealed:
-Diagnoses included Alzheimer disease and atrial fibrillation.
-She was ambulatory.
-She was intermittently disoriented.

Review of Resident #1's Resident Register revealed an admission date of 12/03/25.

Review of Resident #1's care plan dated 04/20/26 revealed:
-She was sometimes disoriented.
-She needed extensive assistance from staff with bathing, dressing, and grooming.
-She was independent with eating, toileting, ambulation, and transferring.

Review of Resident #1's record revealed there was no care plan dated within the first 30 days of admission available for review.

Interview with the Resident Care Coordinator (RCC) on 05/01/26 at 1:12pm revealed:
-The RCC and Director of Clinical Services (DCS) were responsible for ensuring the care plans were completed within 30 days of a resident moving in.
-The DCS was responsible for Resident #1's care plan when she moved in on 12/03/25.
-The RCC and DCS were having a difficult time getting the signed care plans back from the primary care provider (PCP).
-She thought that was why Resident #1 did not have a signed care plan within 30 days of his

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D 253	Continued From page 23 admission. Interview with the Regional Director of Clinical Services on 05/01/26 at 2:56pm revealed: -The DCS started in September 2025. -In January 2026, she discovered the DCS was having a difficult time getting the signed care plan for Resident #1 back from the PCP. -She educated the DCS in January 2026 regarding when care plans were due. -She was not sure why Resident #1 did not have a care plan completed until April 2026. -She expected the care plan to be completed and signed by the PCP withing 30 days of move-in. Interview with the Regional Director of Operations on 05/01/26 at 3:50pm revealed: -It was the DCS's responsibility to ensure the care plans were completed and signed within 30 days of the residents moving in. -She expected the care plans to be completed and signed on time. Attempted telephone interview with the DCS on 04/30/26 at 4:00pm was unsuccessful. Attempted interview with the Interim Administrator on 04/30/26 at 4:00pm was unsuccessful.	D 253		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this	D 276		

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D 276	Continued From page 24 Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement orders from the primary care provider (PCP) for 1 of 5 sampled residents (#1) who had an order for daily blood pressure and pulse checks. The findings are: Review of Resident #1's current FL2 dated 11/25/25 revealed: -Diagnoses included Alzheimer disease and atrial fibrillation. -She was ambulatory. -She was intermittently disoriented. Review of Resident #1's signed physician progress note dated 03/16/26 revealed an order to check blood pressure (BP) and pulse daily for 14 days. Review of Resident #1's electronic medication administration record (eMAR) for March and April 2026 revealed there was no entry for BP or pulse checks. Review of Resident #1's vital sign history report for March 2026 revealed: -There was no BP or pulse documented from 03/16/26 - 03/22/26. -The BP and pulse checks were documented from 03/23/26 -04/17/26. Interview with Resident #1's PCP on 05/01/26 at 12:37pm revealed:	D 276		

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-She wrote the order to check Resident #1's BP and pulse checks for 14 days.
-Resident #1 had started on a new medication and she wanted to make sure that Resident #1's BP and pulse did not get too low.
-She expected the order to start on 03/17/26.

Interview with the Resident Care Coordinator (RCC) on 05/01/26 at 1:12pm revealed:
-She knew Resident #1 had an order to check her BP and pulse daily for 14 days.
-It was her responsibility to ensure the BP and pulse order was implemented.
-She did not put the order on the eMAR for the medication aides (MA) to complete because she was not taught to put them on the eMAR.
-She put in a note that will would pop up on the electronic medical record that informed the MAs Resident #1 had daily BP and pulse checks.
-She could not remember why she did not put the order in until a week after it was written.
-It was possible that she did not see the order until a week later.
-It was her responsibility to review the PCP's progress notes for orders.

Interview with the Regional Director of Clinical Services on 05/01/26 at 2:56pm revealed:
-It was the RCC and Director of Clinical Services (DCS) responsibility to review the PCP's progress notes for new orders.
-Vital signs orders should be placed on the eMAR so that they were not missed.
-She expected the order to be implemented at the time the PCP wrote the order.

Telephone interview with the Regional Director of Operations on 05/01/26 at 3:50pm revealed:
-It was the responsibility of the RCC and DCS to ensure written physician orders were

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D 276	Continued From page 26 implemented. -She expected physician orders to be implemented the day they were received from the PCP. Attempted telephone interview with the DCS on 04/30/26 at 4:00pm was unsuccessful. Attempted interview with the Interim Administrator on 04/30/26 at 4:00pm was unsuccessful. Based on observation and record review it was determined Resident #1 was not interviewable.	D 276		
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.	D 283		

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(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
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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure foods stored in the kitchen and the secured unit were free from contamination related to opened foods, food that was not labeled or dated, and expired food.

The findings are:

Review of the Environmental Health Services (EHS) inspection report dated 03/20/26 revealed:
-The kitchen sanitation score was 97.5.
-The kitchen received a 1.5-point deduction for expired liquid eggs not being disposed of.

Observation of the refrigerator on 04/30/26 at 3:36pm revealed:
-There was a pitcher of liquid that was uncovered, not labeled, or dated.
-There was a second pitcher of liquid that was covered, but the plastic wrap only covered one-half of the pitcher, and it was not labeled or dated.
-There was a container of a yellow creamy substance that was labeled or dated.
-There was a container of a cucumber salad that had been opened but was not dated.
-There was a container of cottage cheese that had a manufacturer's expiration date of 04/13/26.
-There was a container of sour cream dated as opened on 03/31/26.
-The inside of the sour cream container had remnants of shredded cheese and a reddish substance.
-There were multiple containers of leftover food that were covered with a plastic wrap, the plastic wrap was not secured, leaving the contents exposed; the containers were not labeled or

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D 283	Continued From page 28 dated. -There was a box that contained a plastic bag of bacon, the box nor plastic bag was not closed, leaving the bacon exposed. Observation of the freezer on 04/30/26 at 3:44pm revealed there was a box that contained a plastic bag of frozen cookies, neither the box nor the bag were secured, leaving the contents exposed. Interview with the Dietary Manager on 04/30/26 at 3:36pm revealed: -All foods should be labeled and dated; whoever was working was responsible. -He was not sure without looking at the menu when the cottage cheese was served for dessert with fruit, but he thought it may have been on Monday, 04/27/26. -The yellow creamy substance was lemon pudding and was opened earlier in the week. -The cucumber salad was opened last night, 04/29/26. -The sour cream was served with taco salad last night, 04/29/26. Interview with a cook on 05/01/26 at 9:03am revealed: -Whoever cooked was responsible for covering, labeling, and dating leftover foods and opened containers. -She checked when she worked to make sure foods were labeled correctly. -She worked last Wednesday morning, 04/29/26. -She did not know when the residents were served cottage cheese; it could have been on Wednesday, 04/29/26, or Thursday, 04/30/26. -Pitchers of beverages should be covered, labeled, and dated. -When bags were opened that contained food items, the bags should be closed back.	D 283		

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D 283	Continued From page 29 Observation of the kitchenette in the secure unit on 05/01/26 at 9:35am revealed: -There was a gallon jug of milk sitting on the counter. -The milk jug contained approximately 3 cups of milk and was warm to the touch. -There was a small bowl of mixed fruit that was covered but not dated. -There was a disposable cup of mixed fruit with a disposable fork stuck into the fruit; the cup was not covered or dated. -There was a plastic bag of fresh fruit; the bag was not closed, labeled, or dated. -There was a container of a creamy white substance with darker liquid in it. -The container was covered but was not labeled or dated. Interview with a personal care aide (PCA) on 05/01/26 at 9:40am revealed: -The staff in the secured unit were responsible for cleaning the kitchenette, which included cleaning out the refrigerator. -She thought all the fruits were left from yesterday, 04/30/26. -She did not know the milk had been left sitting out. -She threw the milk away; there was not much left anyway". Interview with the Dietary Manager on 05/01/26 at 9:45am revealed: -The staff in the secured unit were responsible for storing food correctly in the refrigerator. -He would make sure the staff had labels and materials to secure the items. Interview with the Regional Director of Clinical Services on 05/01/26 at 3:32pm revealed:	D 283		

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D 283	Continued From page 30 -Leftover food should be stored appropriately, which included being covered and dated. -The Dietary Manager was responsible for ensuring the food was stored correctly. Telephone interview with the Regional Director of Operations on 05/01/26 at 3:59pm revealed: -Leftover food should be labeled, dated, and covered with a lid or a plastic wrap. -Expired food should be discarded.	D 283		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 8 ounces of milk or an equivalent of dairy servings were served three times daily to the residents. The findings are: Review of the facility's census on 04/29/26	D 299		

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D 299	Continued From page 31 revealed 44 residents: 25 in the Assisted Living (AL) and 19 in a secured unit. Based on the recommended servings of 8 ounces of milk three times a day, the facility would use 8.25 gallons of milk per day to serve 44 residents. Observation of the lunch meal service on 04/29/26 from 12:26pm-1:04pm revealed the residents were not offered milk or a dairy alternative during the meal service. Observation of the dining room on 04/30/26 at 7:34am revealed a staff member entered the dining room with 2, gallon jugs of milk. Observation of the breakfast meal service on 04/30/26 between 7:30am-8:18am revealed: -Some of the residents were offered milk in their coffee. -Two residents were given a glass of milk; they were eating cereal. -One resident was asked if she wanted a glass of milk. -The Dietary Manager walked around the dining room with a pitcher of milk, but did not offer milk to all the residents. -No other dairy alternative was offered. Observation of the lunch meal service on 04/30/26 from 12:29pm-1:00pm revealed the residents were not offered milk during the meal service; no other dairy was offered. Observation of the refrigerator on 04/30/26 at 3:54pm revealed: -There was one full gallon of milk. -There was one gallon of milk that contained less than one-half of the gallon remaining. -There was a pitcher of milk that was covered	D 299		

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D 299	Continued From page 32 and dated as 04/30/26. Observation of the freezers on 05/01/26 at 9:30am revealed the facility had a lot of dairy alternatives, including ice cream and yogurt. Observation of the lunch meal service on 04/29/26 at 12:06pm revealed the residents were not offered milk or a dairy alternative during the meal service. Interview with a resident on 04/29/26 at 8:49am revealed: -She was not offered milk to drink with her meals. -She liked milk and would drink milk if it was offered. Interview with a second resident on 05/01/26 at 10:18am revealed: -He liked milk. -He received milk to put in his cereal at breakfast. -He was not offered milk at other meals. -He would like to have milk at other meals. -He was occasionally served other dairy products, but not very often. Interview with a third resident on 05/01/26 at 1:00pm revealed the residents were served ice cream 2 times per week. Interview with a fourth resident on 05/01/26 at 1:10pm revealed they would eat more dairy if they were offered ice cream more often. Interview with a fifth resident on 05/01/26 at 1:20pm revealed they got ice cream occasionally. Interview with a sixth resident on 05/01/26 at 1:30pm revealed: -They would drink milk if it were offered.	D 299		

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D 299	Continued From page 33 -Occasionally, they would eat ice cream when it was offered. Interview with a dietary aide on 04/30/26 at 3:04pm revealed: -He gave milk to the four residents he knew wanted milk at breakfast. -If he offered milk to the other residents, he knew they were going to say no. Interview with a cook on 05/01/26 at 9:03am revealed: -Quite a few residents did not like milk. -She added cheese to the eggs. -She also gave yogurt to residents. -At lunch and dinner, milk was offered, or the residents were offered ice cream or yogurt. Interview with the Dietary Manager on 05/01/26 at 9:15am revealed: -They were pouring out so much wasted milk in the AL dining room that they stopped giving the milk and started offering milk instead. -Milk was served three times per day to the residents in the secured unit. -He asked the residents in the AL dining room if they wanted milk. -There were only two residents who usually wanted a glass of milk. -Milk was offered at breakfast, lunch, and dinner. -He ordered milk from the food supplier, which delivered on Tuesdays. -Milk was left off the order delivered on 04/28/26, so a staff member went to the store and purchased milk. -If he had gone to the store to purchase the milk himself, he would have purchased enough to get through until the next delivery. Interview with the Director of Clinical Services on	D 299		

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D 299	Continued From page 34 05/01/26 at 2:00pm revealed: -She did not know the daily allowance for dairy. -The expectation was that residents were to get dairy products with each meal. Interview with the Regional Director 05/01/26 at 3:55pm revealed: -She was not sure of the recommended daily dairy allowance. -The expectation was that residents were at least offered some type of dairy with each meal.	D 299		
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, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 3 of 3 sampled residents (9, #10, #11) for a resident who had an order for a mechanical soft diet (#9), an order for finger foods (#10), and an order for double portions (#11). The findings are: 1. Review of Resident #11's current FL2 dated 03/04/26 revealed: -Diagnoses included neurotrophic keratitis, cognitive impairment, and chronic kidney disease. -Diet was listed as regular with supplements twice	D 310		

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D 310	Continued From page 35 a day. Review of Resident #11's diet order dated 03/30/26 revealed an order for regular diet double portions. Review of Resident #11's previous diet order dated 03/10/26 revealed an order for finger foods. Review of the diet list provided by the Dietary Manager on 04/29/26 revealed Resident #11 was listed as finger foods, double portions. Review of a second diet list provided on 04/29/26 revealed Resident #11 was listed as finger foods. Review of the lunch menu for a finger food diet for 04/29/26 revealed: -The barbecue turkey should be served as turkey with the sauce on the side. -The macaroni and cheese should be served in wedges. Review of the recipe for macaroni and cheese wedges revealed that frozen macaroni and cheese wedges were to be placed on a baking sheet and cooked for 5-9 minutes, then served 3 wedges. Observation of the lunch meal service on 04/29/26 at 12:34pm-1:00pm revealed: -Resident #11 was served a hamburger bun with chopped barbequed turkey, macaroni and cheese, broccoli, and chocolate cake with icing. -Other residents with a regular meal were served the same food and the same amount of food. -Resident #11 ate 100% of his meal. Review of the lunch menu for a finger food diet for 04/30/26 revealed:	D 310		

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-An alternative to the regular menu, a turkey bacon club sandwich, and a bowl of garden vegetable soup.
-The sandwich should be cut into quarters.
-The fruit had a note to see the recipe.

Review of the recipe for fruits revealed residents should be served orange wedges, bananas, or drained melon who were on a finger food diet.

Observation of the lunch meal service on 04/30/26 at 12:29pm-1:03pm revealed:
-Resident #11 was served a sandwich cut in half, a bowl of soup, and fruit cocktail.
-Other residents with the same meal were served the same amount of food.
-Resident #11 ate 100% of his meal.

Interview with a cook on 05/01/26 at 9:03am revealed:
-Residents who ordered double portions got two of everything; sides would be doubled.
-A [named] resident was to be served double portions.
-The [named] resident was not Resident #11.

Interview with the Dietary Manager on 04/30/26 at 3:13pm revealed:
-Resident #11 had an order for a finger food diet.
-Resident #11 was blind.
-Resident #11 was not served a finger food diet because he did really well with his utensils for eating and preferred to have a regular diet.
-He asked Resident #11 if he wanted finger food, and he said no.
-He had not obtained a new order for a regular diet.

Interview with the Dietary Manager on 05/01/26 at 9:15am revealed:

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-Resident #11 had an order for double portions
-When double portions were served, he went heavier on the sides and would get two meats.
-A [named] cook was new, and he was not sure why Resident #11 was not served double portions.
-He usually made sure double of everything was served.

Interview with Resident #11 on 04/29/26 at 8:46am revealed that he was blind in one eye and "almost" blind in the other eye.

Interview with Resident #11 on 05/01/26 at 8:50am revealed:
-He thought he got "plenty" to eat.
-He managed his fork and spoon fine.

Telephone interview with Resident #11's primary care provider (PCP on 05/01/26 at 12:37pm revealed:
-Resident #11 was ordered double portions because when he moved in, the resident was underweight and was always hungry.
-Resident #11 weighed 135 on admission in March 2026, and on 04/21/26, he weighed 140.
-She expected Resident #11 to be served double portions to make sure the resident was getting enough to eat.

Attempt to obtain Resident #11's weight on 05/01/26 at 11:30am revealed:
-The scale in the AL unit was broken.
-The scale in the secured unit was in the spa, and the spa had flooded.

Refer to the interview with a cook on 05/01/26 at 9:03am.

Refer to the interview with the Regional Director

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D 310	Continued From page 38 of Clinical Services on 05/01/26 at 3:32pm. Refer to the telephone interview with the Regional Director of Operations on 05/01/26 at 3:59pm. 2. Review of Resident #9's current FL2 dated 06/30/25 revealed: -Diagnoses included hypertension, coronary artery disease, and heart failure. -There was an order for chopped meat. Review of Resident #9's current diet order dated 02/09/26 revealed: -There was an order for a mechanical soft diet. -Mechanical soft included ground moist meats, canned fruits and vegetables, well-cooked soft vegetables, and finely chopped fresh fruits and vegetables as tolerated, and soft breads and desserts. Review of the lunch menu for a mechanical soft diet for 04/29/26 revealed the barbecue turkey should be ground. Observation of the lunch meal service on 04/29/26 at 12:34pm-1:00pm revealed: -Resident #9 was served a hamburger bun with chopped barbequed turkey, macaroni and cheese, and three-bean salad. -He ate 100% of his chopped turkey sandwich. -He did not eat his macaroni and cheese or three-bean salad. Review of the breakfast menu for a mechanical soft diet for 04/30/26 revealed the sausage patty should be ground with gravy. Observation of the breakfast meal service on 04/30/26 at 7:34am revealed Resident #9 was served hot cereal, a pancake, and a sausage	D 310		

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D 310	Continued From page 39 patty. Review of the lunch menu for a mechanical soft diet for 04/30/26 revealed fried chicken should be ground with gravy. Observation of the lunch meal service on 04/30/26 at 12:29pm-1:00pm revealed: -Resident #9 was served ground turkey with gravy. -He asked the dietary aide what this was and pushed it to the side. -The Dietary Manager asked the surveyor what he should do since the resident was refusing the meal that was being served as ordered. -The Dietary Manager was encouraged to offer an alternative, which the resident refused. -The Dietary Manager was encouraged to discuss the issue with the Clinical Nurse Specialist. -The Dietary Manager returned from talking with the Clinical Nurse Specialist and provided Resident #9 with chopped chicken and gravy. -Resident #9 choked while eating the chopped chicken and gravy. -Resident #9 did not eat the remainder of his meal. Interview with the dietary aide on 04/30/26 at 3:04pm revealed: -He accidentally gave Resident #9 a whole piece of sausage at breakfast but took it back to the kitchen and cut it up when he realized it. -Resident #9 refused a chopped diet every day. -Resident #9 got choked 1-2 times per week. -He was working one day when he noticed Resident #9 was changing colors, and he knew something was wrong; the Dietary Manager did the Heimlich maneuver. Interview with the Dietary Manager on 04/30/26 at	D 310		

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D 310	Continued From page 40 3:13pm revealed: -A diet order was obtained for Resident #9 because the resident was choking. -Even on a mechanical soft diet, Resident #9 continued to have choking episodes. -Resident #9 was not served ground turkey because the resident turned down ground meats. -He thought that since the turkey was cooked tender with lots of sauce, he thought it would be fine. -Resident #9 did not have any problems eating the barbecue turkey sandwich. -Resident #9's sausage should have been ground with gravy or broth. -The previous Administrator knew Resident #9 was refusing a mechanical soft diet. -He was concerned that if he did not meet the resident part of the way, the resident would not eat at all. -He had to do the Heimlich maneuver on Resident #9 because he choked during a meal; he did not recall what the resident was served. Interview with Resident #9 on 04/30/26 at 11:40am revealed: -He had a barium swallow done about a week ago. -The barium swallow revealed that he needed to have surgery to stretch his esophagus. -When he ate, the food went down, got stuck, and came back up, and he choked on it. -He thought cutting up his food made him choke more often than if he ate regular food and chewed it up himself. -He did not have any difficulty eating the barbecue turkey sandwich for lunch on 04/29/26 because the turkey was not ground up. Interview with Resident #9's primary care provider (PCP) on 04/30/26 at 4:51pm revealed:	D 310		

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-Resident #9's diet ordered had not been changed because she was waiting on the results of a modified barium swallow to be completed to determine what was best for the resident.
-She thought Resident #9 was on a chopped meat diet.
-She was aware Resident #9 was choking.
-She would not recommend a diet change until the modified barium swallow had been completed, and what was recommended based on those results.
-She expected Resident #9's diet to have been served as ordered.

Refer to the interview with a cook on 05/01/26 at 9:03am.

Refer to the interview with the Regional Director of Clinical Services on 05/01/26 at 3:32pm.

Refer to the telephone interview with the Regional Director of Operations on 05/01/26 at 3:59pm.

3. Review of Resident #10's current FL2 dated 11/04/25 revealed diagnoses included major neurocognitive disorder, osteoarthritis, and macular degeneration.

Review of Resident #10's current care plan dated 11/04/25 revealed she needed supervision with eating.

Review of Resident #10's current diet order dated 02/18/26 revealed:
-There was an order for finger foods.
-Finger foods included foods that could be eaten easily with hands instead of cutlery, and offering these could help prolong independence at mealtimes.
-Offering finger foods could also help to improve

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food intake between meals.
-Diet spreadsheets identified appropriate menu options.

Review of the diet list provided by the Dietary Manager on 04/29/26 revealed Resident #10 was listed as finger foods.

Review of the lunch menu for a finger food diet for 04/29/26 revealed:
-The barbecue turkey should be served as turkey with the sauce on the side.
-Sandwiches should be quartered.

Observation of the lunch meal service on 04/29/26 at 12:28pm revealed:
-Resident #10 was served a hamburger bun with chopped barbequed turkey, broccoli florets, and three-bean salad.
-There was barbeque sauce saturating the bottom of the hamburger bun.
-A staff member left the plate sitting in front of Resident #10 and walked away.

Observation of Resident #10 on 04/29/26 at 12:28pm revealed:
-She attempted to pick up a piece of broccoli with her left hand.
-She was looking around the dining room.
-She attempted to pick up a bean from the three-bean salad.
-She continued to look around the dining room.

Interview with Resident #10 on 04/29/26 at 12:29pm revealed:
-She was having a difficult time picking up the piece of broccoli and bean.
-She needed a staff member to put the food in her hand.
-She would not be able to eat the barbequed

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turkey sandwich because there was too much barbeque sauce and it was falling apart.
-She was looking around the dining room for a staff member to help her.

Observation of the dining room on 04/29/26 at 12:31pm revealed:
-A staff member walked over to Resident #10 and cut up the barbequed turkey sandwich.
-The staff member asked Resident #10 if she could pick up the barbequed turkey sandwich.
-Resident #10 stated that she could not pick up the barbequed turkey sandwich because it was falling apart.
-The staff member pulled up a chair and sat next to Resident #10 and assisted her with the meal.

Review of the lunch menu for a finger food diet for 04/30/26 revealed fried chicken would be served as one thigh, black eyed peas should be substituted with green beans, and a lettuce wedge should be served as the second vegetable.

Observation of the lunch meal service on 04/30/26 at 12:10pm revealed:
-Resident #10 was served a piece of fried chicken, green beans, and black-eyed peas.
-A staff member left the plate sitting in front of Resident #10 and walked away.

Observation of Resident #10 on 04/30/26 at 12:10pm revealed:
-Resident #10 attempted to pick up a green bean; it smashed with her attempt.
-Resident #10 attempted to pick up a black-eyed pea and pushed the black-eyed peas off her plate.

Interview with Resident #10 on 04/30/26 at

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12:11pm revealed:
-She could not pick up the black-eyed peas because they were too small.
-She could not pick up the green beans because they were too soft.
-She could not pick up the fried chicken because it was too big and heavy.

Observation of the dining room on 04/30/26 at 12:13pm revealed a staff member assisted Resident #10 with her meal.

Interview with a personal care aide (PCA) on 05/01/26 at 1:58pm revealed:
-Resident #10 could eat finger foods if a staff member assisted her with placing the food in her fingers.
-Resident #10 did not always receive finger foods from the kitchen.
-The staff assisted feeding her if she could not hold the food with her fingers.

Interview with the Resident Care Coordinator (RCC) on 05/01/26 at 1:12pm revealed:
-Resident #10 was not always served finger foods from the kitchen.
-If the staff did not assist Resident #10 she could not eat her meals.

Interview with a cook on 05/01/26 at 9:03am revealed:
-When a sandwich was served to a resident who had been ordered a finger food diet, she cut the sandwich in half.
-She did not know the sandwich should be cut into quarters per the menu, but thought that cutting it into quarters would cause the sandwich to fall apart.

Interview with the Dietary Manager on 04/29/26 at

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D 310	Continued From page 45 3:13pm revealed: -The cook prepared the macaroni and cheese for the finger food diet by adding egg and breadcrumbs to make it stick together, and then the resident was to receive four scoops. -Residents in the secure units' plates were identified as to who was to be served, which plate. -If a resident with an order for finger food was not served a finger food diet, it was because someone gave the resident the wrong plate. Telephone interview with Resident #10's primary care provider (PCP) on 05/01/26 at 1:05pm revealed: -Resident #10 was ordered a finger food diet to help improve food intake, -If Resident #10's finger food diet was not served as ordered, there would be a concern that the resident was not getting enough intake. Refer to the interview with a cook on 05/01/26 at 9:03am. Refer to the interview with the Regional Director of Clinical Services on 05/01/26 at 3:32pm. Refer to the telephone interview with the Regional Director of Operations on 05/01/26 at 3:59pm. _____ Interview with a cook on 05/01/26 at 9:03am revealed: -She had been working at the facility long enough to know what all the residents' diet orders were. -There was also a diet book to look at to find out what each resident was to receive. -She prepared the food according to the menu, which told what could be served or an alternate. Interview with the Regional Director of Clinical	D 310		

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D 310	Continued From page 46 Services on 05/01/26 at 3:32pm revealed: -Diet orders were obtained before a resident moved into the facility. -The Director of Clinical Services was responsible for entering the diet order into the computer system and giving a copy to the Dietary Manager. -She did not think there was an audit system in place to ensure the meals were served as ordered; the Dietary Manager was responsible. -She expected diets to be served as ordered. Telephone interview with the Regional Director of Operations on 05/01/26 at 3:59pm revealed: -It was the responsibility of the Director of Clinical Services to print diet orders, communicate with the Dietary Manager, and ensure the diets ordered matched what the dietary department had posted. -There should be a manager on duty assigned to the dining room. -The diets should be listed so that the staff serving would know what the diets were.	D 310		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer	D 358		

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medications as ordered for 2 of 5 sampled residents (#1 and #5) who had an order for medicated eye drops (#1) and an antibiotic (#5).

The findings are:

1.Review of Resident #5's current FL-2 dated 07/22/25 revealed diagnoses included left femur fracture, dementia, hypertension (high blood pressure), and muscle weakness.

Review of Resident #5's signed physician's order dated 04/11/26 revealed an order for amoxicillin (an antibiotic medication used to treat or prevent infection) 500mg, take 1 tablet every 8 hours until gone.

Review of Resident #5's April 2026 electronic medication administration record (eMAR) from 04/12/26 to 04/18/26 revealed:
-There was an entry for amoxicillin 500mg, take 1 tablet every 8 hours for 7 days, scheduled at 6:00am, 2:00pm, and 10:00pm.
-There were 20 opportunities entered on the eMAR for staff to document amoxicillin as ordered over the 7-day period, rather than 21.
-The amoxicillin was documented as administered 12 out of 20 opportunities.

Telephone interview with Resident #5's dentist on 05/01/26 at 10:35am revealed:
-Resident #5 was prescribed the amoxicillin for an infected tooth nerve.
-Resident #5 was on a medication that prevented him from removing the tooth.
-Resident #5 had to see an orthodontist to have the tooth removed.
-He ordered the amoxicillin to help with the infection until Resident #5 could see an orthodontist.

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D 358	Continued From page 48 -If Resident #5 did not take the 7-day course of amoxicillin, the infection could return faster and become worse. -Resident #5 had dementia and would not remember to take the amoxicillin. -He expected the facility to administer amoxicillin as ordered. Interview with a medication aide (MA) on 05/01/26 at 10:10am revealed: -She was the overnight MA that would administer the 6:00am and 10:00pm dose of Resident #5's antibiotic. -She remembered the antibiotic disappearing one day. -It was determined that the antibiotic was accidentally sent back to the pharmacy. -She did not call the pharmacy to have the medication returned. -She did not call the dentist for directions because she worked overnight and they were not open. -She did not notify management the amoxicillin was not administered as ordered. -She did not know why she did not notify the pharmacy or management. Interview with a second MA on 05/01/26 at 10:20am revealed: -She was the MA that administered Resident #5's 2:00pm dose of antibiotic. -It was determined with another MA that the medication must have been sent back to the pharmacy accidentally. -She did not call the pharmacy to notify the amoxicillin was accidentally returned. -She did not notify management or the dentist for directions. -She was not sure why she did not notify the pharmacy, management, or the dentist that the	D 358		

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D 358	Continued From page 49 amoxicillin was returned to the pharmacy. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/01/26 at 10:49am revealed: -They dispensed 21 tablets of amoxicillin on 04/11/26. -The amoxicillin would have been delivered in the early hours of 04/12/26. -The pharmacy was not notified by the facility the amoxicillin was accidentally sent back. -The pharmacy did not review returned medication unless it was a narcotic. -If they had been notified, they would have dispensed the amoxicillin again that day. Interview with the Resident Care Coordinator (RCC) on 05/01/26 at 1:12pm revealed: -She was not aware Resident #5 did not get the full course of amoxicillin. -She expected to be notified by the MAs so that she could call the dentist for direction. Interview with the Regional Director of Clinical Services on 05/01/26 at 2:56pm reveled: -She was not aware Resident #5 did not get the full course of amoxicillin. -She expected the MAs to notify the pharmacy, Director of Clinical Services (DCS), and dentist for direction. Telephone interview with the Regional Director of Operations on 05/01/26 at 3:50pm revealed: -She expected the MAs to administer the full course of amoxicillin. -She expected the MAs to contact the pharmacy and dentist for direction. 2. Review of Resident #1's current FL2 dated 11/25/25 revealed:	D 358		

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-Diagnoses included Alzheimer disease and atrial fibrillation.
-She was ambulatory.
-She was intermittently disoriented.
-There was an order for dorzolamide/timolol solution (a medicated eye drop used to control pressure in the eye) 2-0.5%, instill 1 drop into each eye twice daily.

Review of Resident #1's February 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for dorzolamide/timolol solution 2-0.5%, instill 2 drops into each eye twice daily scheduled at 9:00am and 9:00pm.
-The dorzolamide/timolol was documented as administered 56 of 56 opportunities.

Review of Resident #1's March 2026 eMAR revealed:
-There was an entry for dorzolamide/timolol solution 2-0.5%, instill 2 drops into each eye twice daily scheduled at 9:00am and 9:00pm.
-The dorzolamide/timolol was documented as administered 62 of 62 opportunities.

Review of Resident #1's April 2026 eMAR from 04/01/26-04/29/26 revealed:
-There was an entry for dorzolamide/timolol solution 2-0.5%, instill 2 drops into each eye twice daily scheduled at 9:00am and 9:00pm.
-The dorzolamide/timolol was documented as administered 55 of 57 opportunities.
- The dorzolamide/timolol was documented as not administered 2 times for Resident #1 being out of the facility.

Observation of medications on hand for Resident #1 on 04/29/26 at 3:12pm revealed:
-There was an opaque bottle of

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dorzolamide/timolol solution 2-0.5% with a dispense date of 01/24/26.
-The dorzolamide/timolol had a sticker on it with a handwritten open date of 02/06/26.
-The dorzolamide/timolol had a small amount of solution left inside.

Telephone Interview with a pharmacist from the facility's contracted pharmacy on 04/29/26 at 4:24pm revealed:
-The bottle of dorzolamide/timolol eye drops had 10ml of solution inside.
-Resident #1's dorzolamide/timolol order was to administer 1 drop into both eyes twice daily.
-The 10ml bottle of dorzolamide/timolol would last 50 days if it was administered as ordered.

Interview with a medication aide (MA) on 05/01/26 at 10:20am revealed:
-She always administered Resident #1's dorzolamide/timolol 9:00am.
-Resident #1 did not refuse the dorzolamide/timolol for her.
-The MAs wrote the date the dorzolamide/timolol was opened and administered for the first time on the medication bottle.

Interview with a second MA on 05/01/26 at 11:11am revealed:
-Resident #1 did not refuse the dorzolamide/timolol for her.
-She always administered the 9:00pm dose of dorzolamide/timolol when she worked.

Telephone interview with Resident #1's primary care provider (PCP) on 05/01/26 at 12:37pm revealed:
-Resident #1 had a diagnosis of glaucoma.
-Dorzolamide/timolol was prescribed to Resident #1 to keep the pressure down in her eyes.

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D 358	Continued From page 52 -If Resident #1 did not receive dorzolamide/timolol as prescribed she was at risk for increased pressure in her eyes. -The increased pressure could cause Resident #1 to have decreased vision or blindness in her eyes. -She expected dorzolamide/timolol to be administered as ordered. Interview with the Resident Care Coordinator (RCC) on 05/01/26 at 1:12pm revealed: -She did medication cart audits monthly but had not started the audit process yet. -She looked to make sure the open date was written on the dorzolamide/timolol. -She did not look to make sure the eye drops were used within the correct timeframe. Interview with the Regional Director of Clinical Service on 05/01/26 at 2:56pm revealed: -Medication cart audits were expected to be completed monthly. -The RCC and Director of Clinical Service (DCS) were responsible for ensuring the medication cart audits were completed. -Eye drops should be checked to ensure they were dated with an open date and if they were being used timely. Attempted interview with the facility's DCS on 04/30/26 at 4:00pm was unsuccessful. Attempted interview with the Interim Administrator on 04/30/26 at 4:00pm was unsuccessful. Based on observation and record reviews it was determined Resident #1 was not interviewable.	D 358		

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D 371	Continued From page 53	D 371		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered in accordance with infection control measures by 1 of 2 medication aides observed during the 8:00am medication pass on 04/30/26, who did not sanitize her hands between the preparation and administration of medications to each resident to prevent the transmission of disease, infection, prevent cross-contamination, and to provide a safe and sanitary environment for residents. The findings are: Review of the facility's Medication Administration policy dated 03/11/25 revealed: -Appropriate infection control practices would be followed during the administration process including washing hands or using hand sanitizer in between residents. -Washing hands after every third resident during medication administration and using hand sanitizer in between each resident was required. Observation of the medication aide (MA), during the medication pass on 04/30/26 between	D 371		

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D 371	Continued From page 54 8:15am and 8:25am revealed: -The MA was walking back to the medication cart from administering medications to a resident. -There was hand sanitizer on the medication cart. -The MA used keys to unlock the medication cart. -She did not sanitize her hands. -She reviewed a resident's electronic medication administration record (eMAR) using the computer keyboard and mouse on the medication cart. -She removed medication cards from the medication cart and prepared 12 oral medications for a resident. -She poured a cup of water. -She locked the medication cart. -She took the medication cup that contained the 12 oral medications to a resident in the dining room and handed the resident the medication cup of 12 tablets and set the cup of water on the table in front of her and observed her swallowing the 12 oral medications with the cup of water provided. -She took the empty medication cup from the resident. -She returned to the medication cart, disposed of the empty medication cup and documented the resident's medications on the eMAR using the computer mouse. -She did not sanitize or wash her hands. Interview with an MA on 04/30/26 at 9:04am revealed: -She washed her hands before starting the medication pass. -She was supposed to use hand sanitizer between each resident. -She did not use the hand sanitizer on the cart because it created a rash on her hands. -She could not remember if she let management know about the hand sanitizer on the cart causing a rash on her hands.	D 371		

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D 371	Continued From page 55 -She had her own personal hand sanitizer that she used but it was in her pocket book and not accessible at the time of the medication pass. -She did not think about using the nearest sink to wash her hands with soap and water. Telephone interview with the facility's contracted primary care provider (PCP) on 05/01/26 at 12:37pm revealed: -The MAs should sanitize their hands between each resident. -Hand hygiene was important to stop the spread of disease in the facility. Interview with the Resident Care Coordinator (RCC) on 05/01/26 at 1:12pm revealed: -The MAs were instructed on 05/01/26 to use hand sanitizer between each resident and wash their hands after the fifth resident. -She did not know that the facility policy was to wash hands after the third resident, using hand sanitizer between each resident. -She was not aware the hand sanitizers on the medication cart created a rash on the MA's hands. -She expected the MA's to use hand sanitizer between each resident. Interview with the Regional Director of Clinical Services on 05/01/26 at 2:56pm revealed: -The MAs were to use hand sanitizer between each resident. -It was important for the MAs to follow hand hygiene guidelines to prevent the spread of infection. Telephone interview with the Regional Director of Operations on 05/01/26 at 3:50pm revealed the staff were expected to follow the infection control process.	D 371		

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D 371	Continued From page 56 Attempted interview with the facility's DCS on 04/30/26 at 4:00pm was unsuccessful. Attempted interview with the Interim Administrator on 04/30/26 at 4:00pm was unsuccessful.	D 371		
D 377	10A NCAC 13F .1006 (a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that self-administered medications stored in a resident's room were maintained in a safe and secure manner for 1 of 1 sampled resident (#6). The findings are: Review of the facility's Medication and Treatment Self-Administration of Medication Policy dated 03/11/25 revealed that all residents who self-administered medications must secure their medications in a lock box and keep their doors locked. Review of Resident #6's current FL2 dated 10/31/25 revealed: -Diagnoses chronic obstructive pulmonary disease (COPD) and hypothyroidism. -There was an order for a breyna nebulizer (used to treat asthma and COPD), one puff twice daily.	D 377		

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D 377	Continued From page 57 -There was an order for levothyroxine 100mg once daily. Review of Resident #6's medication self-administration assessment dated 12/04/25 revealed: -It was the initial assessment. -There was documentation that Resident #6 was fully capable of demonstrating proper/secure medications kept in his room. -Resident #6 had been informed of self-administration procedures, including assessment schedule and safe storage requirements. Review of Resident #6's medication self-administration assessment dated 04/29/26 revealed: -It was a quarterly review. -Resident #6 had now been informed of safe storage and would obtain a lock box. Observation of Resident #6's room on 04/29/26 at 8:40am revealed: -There was a breyna inhaler opened, lying on the shelf at his bed. -There was an unopened box that contained a breyna inhaler. Interview with Resident #6 on 04/29/26 at 8:40am revealed: -He used his inhaler twice daily. -He also had a bottle of levothyroxine in his bathroom medicine cabinet. Observation of Resident #6's room on 05/01/26 at 7:51am revealed: -His door was not locked and did not have a locking mechanism. -There was an inhaler opened, lying on the shelf	D 377		

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D 377	Continued From page 58	D 377		

at his bed.
-There was an unopened box that contained a nebulizer.
-He was not in his room.

Observation of Resident #6's room on 05/01/26 at 10:23am revealed:
-The medication cabinet in the bathroom was not locked.
-There was a bottle of levothyroxine with the directions to take the medication once daily.
-There were four bottles of supplements sitting on an open shelf.
-There was a bottle labeled as atorvastatin 40mg or placebo.

Interview with Resident #6 on 05/01/26 at 10:18am revealed:
-His daughter called him to let him know she ordered him a lock box for his medications, and it should be delivered today, 05/01/26.
-He did not know if anyone had talked to him about how to store his medication.
-The only interview he had about him taking his own medications was prior to him moving into the facility.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/29/26 at 4:53pm revealed:
-She saw documentation that Resident #6 would obtain and administer his own medications.
-Resident #6's breyna inhaler contained a steroid, and if someone took too many doses, it could increase their heart rate.
-If too much of Resident #6's levothyroxine was taken, it could have gastrointestinal effects, increased pulse and blood pressure, and cause headaches.

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D 377	Continued From page 59 Interviewed with a medication aide (MA) on 05/01/26 at 12:40pm revealed: -She had never been told about medicine in a resident ' s room -If a PCA saw medication in a resident room, they should bring it to the MA. -The MA would make the Executive Director aware. -The medication should be in a lock box. Interview with Resident Care Coordinator (RCC) on 05/01/26 at 12:50pm revealed: - No special way to keep the medication in the resident ' s room -The resident ' s room door was always locked. Interview with the Regional Director of Clinical Services on 05/01/26 at 3:32pm revealed: -Medications that were self-administered should be locked in the resident's room. -Residents were told before they moved in that medication needed to be locked if they were going to self-administer their medications. -Staff should look for unlocked medication when in the resident's room. Telephone interview with the Regional Director of Operations on 05/01/26 at 3:59pm revealed: -Residents whose medication was self-administered should keep their medications in their room in a lock box. -The Director of Clinical Services should make sure the resident knew how to store his medications as part of the self-administration assessment. -A lock box should be provided for the resident. Attempted interview with the facility's Director of Clinical Services on 04/30/26 at 4:00pm was unsuccessful.	D 377		

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D 377	Continued From page 60 Attempted interview with the Interim Administrator on 04/30/26 at 4:00pm was unsuccessful.	D 377		