STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001134	A. BUILDING: _____ B. WING _____	R 09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS OF ALAMANCE	1670 WESTBROOK AVENUE BURLINGTON, NC 27215

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey from 09/02/26 through 09/03/26.	D 000		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served at each meal for 15 of 31 assisted living (AL) residents, in addition to other beverages. The findings are: Observation of the lunch meal service on 09/02/26 between 12:05pm and 12:35pm revealed: -There were 16 residents present for the lunch meal service. -No beverages had been placed on the dining tables prior to the residents being seated. -Ten glasses of water were served to 10 residents upon request, along with other beverages. -Six residents were not served water. Observation of the breakfast meal service on	D 306		

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D 306	Continued From page 1 09/03/26 between 8:00am and 8:38am revealed: -There were 15 residents present for the breakfast meal service. -No water was served to any of the 15 residents. -Other beverages on each table included milk, coffee and juice. Interview with a resident on 09/03/26 at 8:43am revealed: -Beverages served with meals usually included coffee and tea and occasionally juice. -If she wanted water with her meals, she had to ask for it. -She would drink water if it was served to her with each meal. Interview with a second resident on 09/03/26 at 8:51am revealed: -Residents were not served water with each meal. -She would drink water with her meals if it was served to her. -She drank what was served to her and did not ask for water. Interview with a dietary aide on 09/03/26 at 2:06pm revealed: -Beverages were placed on the tables during meals upon requests from the residents. -Most residents drank the same beverages every day. -She thought that residents had to be asked if they wanted water served with meals and was unaware that water was to be served to every resident at every meal whether they requested it or not. -She asked every resident in the dining room daily what beverages they wanted with their meals.	D 306		

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D 306	Continued From page 2 Interview with the Dietary Manager (DM) on 09/03/26 at 2:00pm revealed: -Dietary staff were responsible for serving beverages to residents during meals. -He was aware that all residents were to be served water with every meal. -He was unaware that residents were not served water on 09/02/26 and 09/03/26. -He expected water to be served to every resident at every meal. Interview with the Resident Care Coordinator (RCC) on 09/03/26 at 2:20pm revealed: -Dietary staff were responsible for serving beverages to residents during meals. -She was aware that all residents were to be served water with every meal. -She was unaware that residents were not served water on 09/02/26 and 09/03/26. -She expected water to be served to every resident at every meal. Interview with the Administrator on 09/03/26 at 3:10pm revealed: -She was not aware that all residents were to be served water with every meal. -She was unaware that residents were not served water on 09/02/26 and 09/03/26. -She expected water to be served to every resident at every meal going forward.	D 306		
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.	D 310		

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D 310	Continued From page 3	D 310		

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 1 of 5 sampled residents (#3), who was ordered nectar thickened liquids.

The findings are:

Review of Resident #3's current FL2 dated 04/21/26 revealed diagnoses included dementia, hypertension, type 2 diabetes, and osteoarthritis.

Review of Resident #3's diet order dated 08/20/26 revealed there was an order for nectar thickened liquids.

Observation of the lunch meal on 09/02/26 from 12:02pm to 12:35pm revealed:
-Resident #3 was served water in a 32oz plastic mug.
-The personal care aide (PCA) filled the mug with ice and water; no thickener was added to the water.

Observation of the breakfast meal on 09/03/26 from 9:01am to 9:22am revealed Resident #3 was served milk in an 8oz plastic tumbler; no thickener was added to the milk.

Observation of the refrigerator in the Special Care Unit (SCU) on 09/03/26 at 8:46am revealed:
-There were two 46oz jugs of thickened water in the refrigerator in the SCU.
-There was a 46oz jug of thickened water with lemon in the refrigerator in the SCU.

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D 310	Continued From page 4 -There was a 46oz jug of thickened apple juice in the SCU. Observation of the kitchen on 09/03/26 at 2:10pm revealed: -There were eight 46oz jugs of thickened water in the refrigerator. -There were six 46oz jugs of thickened water with lemon in the refrigerator. -There were eight 46oz jugs of thickened apple juice. Telephone interview with Resident #3's family member on 09/03/26 at 12:02pm revealed: -Staff made her aware that Resident #3 had an issue with swallowing a few weeks ago. -She was not aware the resident had an order for nectar thickened liquids. -She had not witnessed staff giving Resident #3 thickened liquids. Interview with a PCA on 09/03/26 at 9:32am revealed: -She was not aware Resident #3 had an order for nectar thickened liquids. -The Special Care Coordinator (SCC) did not tell her Resident #3 had an order for thickened liquids. -She saw the thickened liquids in the refrigerator but did not know they were for Resident #3. -She had not witnessed Resident #3 cough or choke while drinking. Interview with a medication aide (MA) on 09/03/26 at 9:42am revealed: -She was not aware Resident #3 had an order for nectar thickened liquids. -She had not seen the thickened liquids in the refrigerator in the SCU. -She knew the resident had an order for a pureed	D 310		

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D 310	Continued From page 5	D 310		

diet and asked a PCA last week if the resident was on thickened liquids and was told "no".

Interview with another MA on 09/03/26 at 11:09am revealed she did not know Resident #3 had an order for nectar thickened liquids.

Interview with the Dietary Manager (DM) on 09/03/26 at 2:15pm revealed:
-He was aware Resident #3 had an order for nectar thickened liquids.
-He ordered pre-thickened liquids monthly.

Telephone interview with a representative from the facility's contracted Hospice Provider on 09/03/26 at 10:16am revealed:
-The facility reported that Resident #3 aspirated while drinking thin liquids.
-He wrote an order on 08/20/26 for nectar thickened liquids for Resident #3.
-He expected to be notified if the resident was not receiving thickened liquids.
-He was concerned the resident would aspirate if she continued to receive unthickened liquids.

Interview with the Resident Care Coordinator (RCC) on 09/03/26 at 11:32am revealed:
-She was aware Resident #3 had an order for nectar thickened liquids.
-She made staff in the SCU aware that Resident #3 had an order for thickened liquids.
-The thickener was placed in the refrigerator in the SCU.

Interview with the SCC on 09/03/26 at 11:44am revealed:
-She knew Resident #3 had an order for nectar thickened liquids.
-She was not sure why the PCA did not give nectar thickened liquids to Resident #3.

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D 310	Continued From page 6 -The thickener was placed in the refrigerator after the order was received. -She had not seen the resident coughing while drinking fluids. Interview with the Administrator on 09/03/26 at 11:58am revealed: -She expected therapeutic diets to be served as ordered. -She was concerned Resident #3 would choke if she was not receiving nectar thickened liquids. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.	D 310		