STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL039018	A. BUILDING: _____ B. WING _____	R 06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRE' MORE MANOR ALF	6016 PINE TOWN ROAD OXFORD, NC 27565

(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 and follow-up survey from 06/23/26 to 06/24/26.	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: Based on observations, interviews, and record reviews, the facility failed to ensure that 4 of 4 exit doors had a sounding device engaged and continuously audible when the doors were opened, which was accessible to a resident with a diagnosis of dementia and was constantly disoriented (#5). The findings are:	D 067		

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D 067	Continued From page 1 Review of the facility's Assisted Living (AL) roster on 06/23/26 revealed a census of 20 residents. Observation of the four exit doors on 06/23/26 at various times between 8:00am and 8:30am revealed: -There was a sensor near each exit door that chimed when someone walked past the sensor. -The doors were not locked. -There was an alarm device mounted with one component on the door and the corresponding component on the door frame. -The alarm system was designed to produce an audible alarm when the two components were separated. -An alarm sounded when the door was opened. -The area outside of each exit door was not enclosed. Observation of the front entrance door on 06/23/26 at 8:00am revealed a faint alarm sounded when the door was opened and stopped when the door was closed. Observation of the women's hall exit door on 06/23/26 at 8:12am revealed: -The door was not locked. -The exit door had a double chime heard when the door was open. -There was no alarm heard while the door was held open. -There was no staff in the hallway, and no one checked to see why the door alarm had sounded. Observation of the men's hall exit door on 06/23/26 at 8:34am revealed: -The door was not locked. -The exit door had an alarm heard when the door was open.	D 067		

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D 067	Continued From page 2 -The alarm continued to sound while the door was open. -The alarm stopped when the door was closed. Observation of the activity room exit door on 06/23/26 at 9:02am revealed: -The door was not locked. -The exit door had an alarm heard when the door was open. -The alarm continued to sound while the door was open. -The alarm stopped when the door was closed. Observation of the front entrance door on 06/24/26 at 7:46am revealed no alarm sounded when the door was opened. Review of Resident #5's current FL2 dated 01/19/26 revealed: -Diagnoses included neurocognitive disorder. -She was constantly disoriented. -She was semi-ambulatory. Review of Resident #5's Resident Register dated 09/13/24 revealed she was forgetful and needed reminders. Review of Resident #5's care plan dated 01/19/26 revealed: -Diagnoses included dementia. -She had significant memory loss and had to be directed. -She required limited assistance with ambulation. Interview with Resident #5 on 06/24/26 at 12:29pm revealed: -She was able to answer questions related to her date of birth, where she was born, how many children she had, and their names. -She did not go outside unless she was with staff.	D 067		

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D 067	Continued From page 3 -She did not go outside by herself. Telephone interview with Resident #5's Guardian on 06/24/26 at 3:55pm revealed: -Resident #5 had no history of wandering. -Resident #5's memory was "okay". -Resident #5 had never attempted to leave the facility. Telephone interview with Resident #5's primary care provider (PCP) on 06/23/26 at 3:00pm revealed: -She would classify Resident #5 as having moderate dementia. -Resident #5 was not a "wanderer". -Resident #5 did "sundown" per the facility staff. -She would recommend that Resident #5 have supervision when outside the facility due to fall precautions. Interview with a personal care aide (PCA) on 06/24/26 at 10:15am revealed: -Resident #5 had short-term memory loss. -She would ask a question and come back in 5 minutes and ask the same question. -Resident #5 had talked about wanting to go home but had never gone to the exit doors. -Resident #5 walked to and from her room, the television room, and the dining room. -When she heard the door alarms, she looked at the door, and if she did not see anyone at the door, she went to the door to make sure no one went outside. -If she did not look at the exit door that was opened on 06/23/26, it may have been because she was busy with another resident. -The door alarms stopped when the doors closed. -She did not have to go to the door to turn off the door alarms. -There were two residents who needed two staff	D 067		

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D 067	Continued From page 4	D 067		

people to provide personal care and transfers.
-There were times when there were only two staff members working.
-If both staff members were in a resident's room when a door alarm was heard, she would make sure the resident was safe and then go check the door alarms to ensure no one went outside.

Interview with a medication aide (MA) on 06/24/26 at 11:37am revealed:
-Resident #5 was disoriented at times.
-Resident #5 sometimes remembered and sometimes did not.
-Resident #5 had asked why she was at the facility and talked about going home.
-There were multiple residents who required two staff members to provide personal care/transfers.
-When a resident was close to the door, the sensors chimed to let staff know someone was near the exit doors.
-The exit doors also had door alarms to alert staff when someone had opened a door.
-If she were in the middle of care with a resident, one staff member would take care of the resident while the other staff member went and checked on the exit doors.
-When a door alarm was heard, all the exit doors were checked.
-When the exit door was opened, the door alarmed until the door closed back.

Interview with the Resident Care Coordinator (RCC) on 06/24/26 at 2:06pm revealed:
-Resident #5's memory "comes and goes".
-Resident #5 had a little bit of confusion.
-Resident #5 got really turned around at times.
-The facility had double-door alarms.
-When someone was close to the exit doors, an alarm was heard.
-Each door also had an alarm that sounded when

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D 067	Continued From page 5 the door was opened and stopped when the door was closed. -Staff checked the doors to see if anyone had exited the facility when an alarm was heard. -Resident #5 had never "wandered" and had not been seen near an exit door. Interview with the Administrator on 06/24/26 at 2:44pm revealed: -Resident #5 was oriented to herself and place. -Resident #5, at times, did ask repetitive questions. -The exit doors had a sensor that alarmed when someone was near the doors. -Each door also had an alarm that sounded when the door was opened. -She had turned the door alarm off on the entrance door on 06/23/26 during an outside activity and forgot to turn it back on. -She did not know the door alarms needed to alarm until they were turned off at the door.	D 067		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the	D 125		

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D 125	Continued From page 6	D 125		

facility failed to ensure 1 of 3 sampled medication aides (MA) (Staff A) had successfully passed the written MA examination within 60 days of hire as a MA.

The findings are:

Review of Staff A's personnel record revealed:
-Staff A was hired as a personal care aide (PCA) on 11/20/24.
-There was documentation Staff A completed the MA 15-hour training course on 10/21/25.
-There was documentation Staff A completed the MA Clinical Skills Competency Validation checklist on 10/21/25.
-There was no documentation Staff A had passed the State written MA examination.

Review of a resident's electronic medication administration record (eMAR) revealed:
-There was documentation Staff A administered medications 13 of 30 days in April 2026.
-There was documentation Staff A administered medications 14 of 31 days in May 2026.
-There was documentation Staff A administered medications 11 of 22 days from 06/01/26 to 06/22/26.

Telephone interview with the MA on 06/24/26 at 12:36pm revealed:
-She worked 7:00pm to 7:00am as a PCA and MA
-She most recently administered medications last night, 06/23/26.
-She took the MA 15-hour training course and had the MA Clinical Skills Competency Validation checklist completed by the Administrator.
-She took the State MA written examination about one month ago, but she did not pass the exam.
-She had to make an appointment to re-take the

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D 125	Continued From page 7 exam. -She had not taken the 15-hour class again. -The Administrator had been working with her and passing medications to help her pass the test. Interview with the Administrator on 06/24/26 at 12:24pm revealed: -Staff A had completed the MA 15-hour training course. -She had completed the MA Clinical Skills Competency Validation checklist for Staff A. -Staff A had taken the State written MA examination, but she did not remember when. -Staff A did not pass the State written MA examination. -She had worked with Staff A on areas that she missed on the State written MA exam. -She was constantly reviewing MA training with Staff A -She had not completed another MA training class. -Staff A was still passing medications.	D 125		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 3 sampled residents (#2) related to a resident whose fingerstick blood sugar (FSBS) was less than 70. The findings are:	D 273		

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D 273	Continued From page 8 Review of Resident #2's current FL-2 dated 04/07/26 revealed diagnoses included Alzheimer's disease with dementia, diabetes mellitus type 2, hypertensive disorder, hyperlipidemia and peripheral arterial disease. Review of Resident #2's signed physician's order dated 04/27/26 revealed there was an order for FSBS checks with meals and at bedtime; notify the Primary Care Provider (PCP) if the FSBS reading was less than 70 or greater than 400. Review of Resident #2's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks with meals and at bedtime with a scheduled time of 8:00am, 12:00pm, 5:00pm and 8:00pm; notify the PCP if the FSBS reading was less than 70 or greater than 400. -There was documentation on 05/28/26 at 8:00pm of a FSBS reading of 57. -There was documentation on 05/31/26 at 8:00pm of a FSBS reading of 65. Review of Resident #2's June 2026 eMAR from 06/01/26 to 06/22/26 revealed: -There was an entry for FSBS checks with meals and at bedtime with a scheduled time of 8:00am, 12:00pm, 5:00pm and 8:00pm; notify the PCP if the FSBS reading was less than 70 or greater than 400. -There was documentation on 06/02/26 at 8:00pm of a FSBS reading of 57. -There was documentation on 06/06/26 at 8:00pm of a FSBS reading of 53. Review of Resident #4's record revealed there was no documentation that the PCP was notified of FSBS readings below 70 on 05/28/26,	D 273		

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D 273	Continued From page 9 05/31/26, 06/02/26, and 06/06/26. Telephone interview with a representative from Resident #2's PCP office on 04/23/26 revealed there was no documentation that the facility had notified Resident #2's PCP of FSBS readings below 70 in Resident #2's record. Telephone interview with Resident #2's PCP on 06/23/26 at 3:03pm revealed: -She was not notified of Resident #2's FSBS readings below 70. -If parameters for FSBS readings were ordered then she should have been notified. -She had ordered a long acting insulin for Resident #2 at bedtime. -She would have ordered Resident #2's long acting insulin to be held at bedtime when his FSBS were below 70. -Resident #2 should have been given a snack and the FSBS rechecked 15 minutes after the snack to ensure his FSBS increased. Telephone interview with the medication aide (MA) on 06/24/26 at 12:36pm revealed: -She checked Resident #2's FSBS at 8:00pm. -Resident #2 had several FSBS readings below 70. -She did not notify the PCP when Resident #2's FSBS were below 70. -She told the on coming MA at 7:00am the following morning about the FSBS readings below 70. -The MA was more experienced and the MA would know what to do. -She did not know the PCP was to be notified of a FSBS reading below 70. -She did not remember seeing that in the order on the eMAR.	D 273		

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Interview with a second MA on 06/24/26 at 1:55pm revealed:
-She did not recall receiving report about Resident #2 having a low FSBS
-The Resident Care Coordinator (RCC) should have been notified about Resident #2's low FSBS.
-The RCC was the one who contacted the PCP

Interview with the RCC on 06/24/26 at 2:08pm revealed:
-When he needed to speak to the PCP he would call, leave a message and they would return the call the same day,
-He was not aware Resident #2 had FSBS readings below 70.
-He did not notify the PCP because he was not aware.
-He knew Resident #2 had an order for FSBS parameters but he had not audited the eMARs to see what the FSBS readings were.
-The MA should have notified the RCC or the Administrator of the FSBS reading that was below 70.

Interviewed with the Administrator on 06/24/26 at 2:42pm revealed:
-The MA should have contacted the PCP, the RCC or the Administrator for FSBS readings below 70.
-She expected the PCP to be notified when there was an ordered parameter.
-She was concerned because the PCP was not notified and the resident was not treated.
-The resident should have been give a snack for a FSBS below 70.
-His FSBS could have dropped lower during the night without treatment.

Attempted interview with a third MA on 06/24/26

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D 273	Continued From page 11 at 1:00pm was unsuccessful.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that all food items stored by the facility were protected from food related contamination in the refrigerator and freezer, and that non-perishable food items were properly stored and food and beverages served in resident rooms were observed to be uncovered during transport from the kitchen to the resident rooms.	D 283		

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D 283	Continued From page 12 The findings are: 1. Observation of the shelves in the dry storage room on 06/23/26 at 8:39am revealed: -There was an opened bag of powdered sugar sealed closed with a twist tie with an opened date of 05/25/26 and a discard date of 06/15/26. -There was an opened bag of seafood breader in a zipped locked bag with an opened date of 05/10/26 and a discard date of 06/10/26. -There was a 25-pound bag of flour that had been torn open with the contents exposed. -There was a box of opened saltine crackers that contained an opened sleeve of crackers that were not sealed. -There was an 11-ounce box of opened cereal, the packaging was not sealed and the contents were exposed. Observation of the chest freezer on 06/23/26 at 8:44am revealed: -There was a large, clear bag that contained toast that was sealed with a twist tie but was not labeled. -There was a large, clear bag that contained meat balls that as sealed with a twist tie and was not labeled. -There were three bags of a sealed, frozen, breaded food product that was not labeled or dated. Observation of the upright freezer on 06/23/25 at 8:47am revealed: -There was frozen, breaded food in a zipped-locked bag dated 04/28/26 to 05/28/26. -There were various sealed bags of frozen foods that were not labeled. Observation of the refrigerator at 8:51am revealed:	D 283		

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D 283	Continued From page 13 -There was a cup ½ full of a white liquid that was uncovered and not labeled. -There was a bottle of mayonnaise with a best if used by dated of 06/24/ 26. -There were three opened containers of broth, a chicken, a beef, and a vegetable, that were not dated when opened. Interview with the cook on 06/24/26 at 10:43am revealed: -The dietary staff clean day to day as we work. -Food that had been opened and stored in the refrigerator should be discard after 5 days. -All opened food in the refrigerator should be labeled with date opened and date to discard. -Food stored in the freezer should be tossed after a month. -The floor should have been sealed closed after being opened; it would have to be discarded now. -Any food opened and stored in the dry storage closet should be sealed and dated after opening. Interview with the Dietary Manager (DM) on 06/24/26 at 1:08pm revealed: -All foods opened should be resealed with the date the food was opened. -When the 25 pound bag of flour was opened it should have been placed in the flour bin with the top over it. -When the weekly stock was delivered all expired food should have been removed and discarded. -He did not realize once he removed sealed packages of food from the box that the food needed to be labeled. Interview with the Administrator on 06/24/26 at 2:44pm revealed: -She expected the food to be labeled when opened. -She expected food containers to be sealed.	D 283		

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D 283	Continued From page 14 -She expected outdated food to be discarded. -There was a possibility of a resident getting sick with expired food in the facility and the possibility of it being served. 2. Observation of the breakfast meal service being delivered to residents' rooms on on 06/23/26 at 8:27am revealed: -There were two plates of food on a cart, covered with a metal top. -The beverages on the cart were not covered. -The staff member pushed the cart down the hallways to deliver the meals. -The cart was left in the hallway unattended while the staff member opened the resident's door, went into the resident's room, moved the bedside table by the bed, and placed the meal on the bedside table. -The staff member did not wear gloves, nor did she wash her hands between resident rooms. Observation of the lunch meal service being delivered to residents' rooms on 06/23/26 at 1:10pm revealed: -There were three plates of food on a cart; they were covered with a metal top. -The beverages on the cart were not covered. -There were three containers of Jello that were not covered. -The staff member pushed the cart down the hallways to deliver the meals. -The cart was left in the hallway unattended while the staff member opened the resident's door, went into the resident's room, moved the bedside table by the bed, and placed the meal on the bedside table. -The staff member did not wear gloves, nor did she wash her hands between resident rooms. Observation of the breakfast meal service being	D 283		

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delivered to residents' rooms on 06/24/26 at 8:06am revealed:
-There were two plates of food on a cart; they were covered with a metal top.
-The beverages on the cart were not covered.
-The staff member pushed the cart down the hallways to deliver the meals.
-The cart was left in the hallway unattended while the staff member opened the resident's door, went into the resident's room, moved the bedside table by the bed, and placed the meal on the bedside table.

Interview with a medication aide (MA) on 06/24/26 at 11:37am revealed:
-The kitchen staff prepared the food carts to be delivered to resident rooms.
-She forgot to wear gloves.
-She noticed the beverages were not covered.
-She saw that the Jello cups were not covered.
-The dietary staff should have put tops on the food items.

Interview with a cook on 06/24/26 at 10:47am revealed:
-Plates that were being delivered to resident rooms were covered.
-She did not have covers for the beverages.
-The Jello cups should have been covered.
-Food and beverages should be covered to keep anything from getting into them.

Interview with the Dietary Manager (DM) on 06/24/26 at 1:08pm revealed that all food items and beverages transported from the kitchen to a resident's room should be covered for sanitation reasons, in order to prevent contamination.

Interview with the Administrator on 06/24/26 at 2:44pm revealed:

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D 283	Continued From page 16 -All food items and beverages should be covered when transported from the kitchen to a resident's room. -If the beverages and food items were not covered, the sanitation of the food would not be maintained.	D 283		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that residents were provided with napkins during meal services in both the dining room and tray deliveries to residents rooms . The findings are: 1. Observation of the breakfast meal service being delivered to residents' rooms on 06/23/26 at 8:27am revealed: -There were two plates of food on a cart,	D 286		

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beverages, and silverware.
-There were no napkins on the cart.

Observation of the lunch meal service being delivered to residents' rooms on 06/23/26 at 1:10pm revealed:
-There were three plates of food on a cart, beverages, a dessert, and silverware.
-There were no napkins on the cart.

Observation of a resident in her room on 06/23/26 at 1:13pm revealed:
-The resident was lying in her bed.
-She was holding both hands in the air.
-She had a plate on her over-the-bed table with fried chicken wings, black-eyed peas, and greens.

Interview with the resident on 06/23/26 at 1:25pm revealed:
-My hands and lips are greasy, and I do not have anything to wipe my hands with.
-When she ate in her room, she was not given a napkin.
-She had not asked for a napkin and usually made do, but today, 06/23/26, she needed a napkin.

Interview with a second resident on 06/23/26 at 1:28pm revealed:
-The staff never brought him a napkin when they delivered his meals.
-He usually made do using tissues, indicating a box of tissues on his over-the-bed table.

Interview with a third resident on 06/23/26 at 1:32pm revealed:
-The staff never brought him a napkin with his meals.
-He just "made do".

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D 286	Continued From page 18 Observation of the breakfast meal service on 06/24/26 at 8:06am revealed: -There were two plates of food on a cart, beverages, and silverware. -There were no napkins on the cart. Interview with a medication aide (MA) on 06/24/26 at 11:37am revealed: -The kitchen staff prepared the food carts to be delivered to resident rooms. -She had not thought about napkins for meals delivered to the residents' rooms. Interview with a cook on 06/24/26 at 10:47am revealed that napkins should be provided to residents who ate in their rooms; she had forgotten to place napkins on the food cart. Interview with the Dietary Manager (DM) on 06/24/26 at 1:08pm revealed that he expected napkins to be given to the residents who ate in their rooms. Interview with the Administrator on 06/24/26 at 2:44pm revealed: -She expected a warm towel and napkins to be provided with every meal delivery to residents who are in their rooms. -It was concerning that residents were not provided with a way to clean their hands. 2. Observation of the breakfast meal service in the dining room on 06/23/26 at 8:08am revealed: -There were 17 residents in the dining room for the breakfast meal. -Some residents had begun to eat breakfast while others were waiting to be served breakfast. -The place setting did not include a napkin or a warm, moist towel.	D 286		

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D 286	Continued From page 19 Observation of the breakfast meal service in the dining room at various times on 06/24/26 between 7:52am 8:30am revealed: -Resident were brought to the dining room for breakfast meal. -Residents were served their breakfast meal that included a toasted English muffin with jelly. -Residents were using their hands to pick up the toasted English muffin with jelly; resident hands became sticky. -A resident asked a personal care aide (PCA) for something to wipe his hands on. -The PCA removed a warm, moist towel from the warmer and gave it to the resident. -The aide gave all the residents a warm, moist towel; all residents had started eating and some had finished when the towels were given to the residents. Interview with a PCA on 06/24/26 at 10:17am revealed: -Each resident gets a warm, moist towel at each meal -She gave them to the residents after they started eating. -The residents should used them in place of paper napkins. -They use to have the paper napkins but the administrator thought this would be better. -She did not realize the residents did not have a napkin or a moist, warm, towel yesterday morning for breakfast, 06/24/26. Interview with the cook on 06/24/26 at 10:43am revealed: -A place setting consisted of a moist, warm towel. -Any staff could get the towels from the warmer and place them on the table for the residents.	D 286		

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D 286	Continued From page 20 Interviewed with the Administrator on 06/24/26 at 2:42pm revealed: -She implanted the warm, moist towel in place of napkins. -It was easier for the residents to clean their hands. -Any staff could place the towels at the resident's place setting.	D 286		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure there were matching therapeutic diet menus for food service staff guidance for 1 of 2 sampled residents (#1) who had a physician's order for a 1800-calorie, heart-healthy diet. The findings are: Review of Resident #1's current FL2 dated 04/24/26 revealed diagnoses included dementia, hypertension, and atrial fibrillation.	D 296		

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D 296	Continued From page 21 Review of Resident #1's hospital discharge summary dated 06/03/26 revealed an order for a 1800-calorie, heart-healthy diet. Observation of the kitchen on 06/23/26 at 8:45am revealed there was no therapeutic diet menu available for food service staff guidance for a 1800-calorie, heart-healthy diet. Review of the regular diet menu for the breakfast meal on 06/23/26 revealed the residents were to be served 6-ounces of vitamin C fortified juice, 1 cup of hot or cold cereal, 1 waffle with 1/2 cup of strawberries and 1-ounce of whipped cream, 1 egg of choice, 8-ounces of milk and 8-ounces of coffee. Observation of Resident #1's room on 06/23/26 at 8:27am revealed: -Resident #1 was in bed, asleep. -A breakfast plate was left on her bedside table that included four sausage links, scrambled eggs, oatmeal, and a glass of orange juice. Observation of Resident #1's room on 06/23/26 at 8:32am revealed the breakfast meal had been removed from the bedside table; Resident #1 remained asleep. Observation of the dining room on 06/23/26 at 12:00pm revealed: -Resident #1 was sitting at the dining room table. -Her breakfast plate had been placed in front of her. -Her sausage links had been cut into bite-sized pieces. -Resident #1 was being encouraged to eat by staff members. -Resident #1 ate twenty-five percent of her breakfast.	D 296		

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D 296	Continued From page 22 Review of the regular lunch menu for 06/23/26 revealed the residents were to be served 4-ounces of oven fried chicken, 1/2 cup of rice pilaf, 1/2 cup of collard greens, 1 biscuit, 2 homemade cookies, 8-ounces of milk and 8-ounces of beverage of choice. Observation of the lunch meal on 06/23/26 at 1:00pm revealed: -Resident #1 was served ground fried chicken, black-eyed peas, and turnip greens. -Resident #1 ate 1/2 of the ground fried chicken and 1/2 of the black-eyed peas. Interview with a cook on 06/24/26 at 10:47am revealed: -She had not seen a diet order for Resident #1 for a 1800-calorie, heart-healthy diet. -Diet orders were reviewed by the Resident Care Coordinator (RCC) and the Administrator. -The RCC gave her an updated diet list when changes were made. Interview with the Dietary Manager (DM) on 06/24/26 at 1:08pm revealed: -The current diet order list was provided by the RCC. -He did not know if the facility had a menu for a 1800-calorie, heart-healthy diet. -If he did not have a menu for a 1800-calorie, heart-healthy diet, he would have to reach out to the company that provided their menus. -If there was no menu available for a 1800-calorie, heart-healthy diet, he would have reached out to the resident's primary care provider (PCP) to discuss other diet options that were available. Interview with the RCC on 06/24/26 at 2:06pm	D 296		

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D 296	Continued From page 23 revealed: -He reviewed Resident #1's hospital discharge summary dated 06/03/26. -He did not see the order for a 1800-calorie, heart-healthy diet. -If he had seen the diet order, he would have created a new diet list for the kitchen to use as a guide. Interview with the Administrator on 06/24/26 at 2:44pm revealed: -She and the RCC were responsible for reviewing Resident #1's hospital discharge summary. -She did not see the order for Resident #1 to have a 1800-calorie, heart-healthy diet -She did not know if the kitchen had a menu for a 1800-calorie, heart-healthy diet. -She would have talked to Resident #1's PCP to discuss diet options available. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable. Attempted telephone interview with Resident #1's PCP on 06/24/26 at 4:15pm was unsuccessful.	D 296		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.	D 298		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the residents were offered snacks three times per day.

The findings are:

Review of the facility's current census on 06/23/26 revealed there were 20 residents residing in the facility.

Review of the week at a glance menu revealed snacks were to be served at 11:00am and 7:00pm.

Interview with the resident on 06/23/26 at 8:40am revealed:
-He was not offered snacks every day.
-If he was offered a snack, it was usually something full of sugar, and he did not eat a lot of sugar.

Interview with a second resident on 06/23/26 at 8:46am revealed:
-She was offered a snack once a day at 11:00am.
-She was not offered snacks at any other time.

Interview with a third resident on 06/23/26 at 8:54am revealed:
-She was given a snack every day at 11:00am.
-She usually saved part of her snack to eat at bedtime because she got hungry.
-She was not provided with a snack at bedtime.

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D 298	Continued From page 25 Interview with a personal care aide (PCA) on 06/24/26 at 10:29am revealed that snacks were given to the residents at 11:00am and 7:00pm by the dietary staff. Interview with a medication aide (MA) on 06/24/26 at 11:37am revealed: -Snacks were served twice a day, at 11:00am and 7:00pm. -Dietary staff served the 11:00am snack, and the care staff served the 7:00pm snack. -The dietary staff left a bucket of snacks for the care staff to serve at 7:00pm. Interview with a cook on 06/24/26 at 10:47am revealed: -Snacks were provided at 11:00am and 7:00pm. -She prepared a container full of snacks for staff to provide to the residents at 7:00pm. -She did not know why the residents reported they were not served snacks at 7:00pm. -She had returned to work at 7:00am and had seen that the container was still full of snacks. -She did not know a snack was to be served between the lunch and dinner meal service. Interview with the Dietary Manager (DM) on 06/24/26 at 1:08pm revealed: -Snacks were served three times daily: between breakfast and lunch, and after dinner. -He expected a snack to be served between lunch and dinner. Interview with the Administrator on 06/24/26 at 2:44pm revealed: -Snacks should be served three times per day. -She thought snacks were served three times per day, between meals and at bedtime. -She expected snacks to be served three times	D 298		

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D 298	Continued From page 26 per day, between meals and at bedtime. -She was concerned the residents may be hungry if snacks were not served.	D 298		
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 dairy serving was served three times daily to the residents. The findings are: Review of the facility's current census on 06/23/26 revealed there were 20 residents residing in the facility. Review of the week at a glance menu for the 06/23/26 and 06/24/26 revealed 8-ounces milk was to be served three times a day with meals.	D 299		

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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
D 299	Continued From page 27 Review of the U.S. Department of Agriculture Dietary Guidelines for Americans revealed: -Adults aged 19-59 and 60+ should consume a minimum of the equivalent of 3 cups of a dairy item daily for a 1600-calorie diet. -Recommendations for daily dairy servings included 1 cup (8 ounces) of whole milk, 2% milk, 1% milk, non-fat/skim milk, buttermilk, lactose-free milk, evaporated milk, and fortified soy milk. -Milk-based desserts included in dairy servings were 1 cup of frozen yogurt, pudding, sherbet, ice cream, and a dairy-based smoothie. -Yogurt included in dairy servings was 1 cup of milk-based yogurt, soy yogurt, and kefir. -Cheese included in dairy servings was one and a half ounces of sliced or cubed hard or soft natural cheese, or one-third of a cup of shredded hard or soft natural cheese; cottage cheese was a 2-cup serving, and ricotta cheese was a half-cup serving. -The dairy serving equivalent of processed American cheese was 2 one-ounce slices or 2 ounces. -Cream cheese, sour cream, and cream were not included as a dairy equivalent due to their low calcium content. -Plant-based milks other than soy milk were not included in an equivalent in the dairy group, even though they may contain calcium, because their overall nutritional content was not similar enough to dairy milk and soy milk. Observation of the refrigerator on 06/23/26 at 8:48am revealed: -There was one unopened gallon of whole milk. -There were two gallons of 2% reduced fat milk; one unopened and one opened and ½ empty. 1. Observation of the breakfast meal service	D 299		

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D 299	Continued From page 28 being delivered to residents' rooms on 06/23/26 at 8:27am revealed: -There were two plates of food on a cart and beverages. -There was no milk or other dairy on the cart. Observation of the lunch meal service being delivered to residents' rooms on 06/23/26 at 1:10pm revealed: -There were three plates of food on a cart and beverages. -There was no milk or other dairy on the cart. Observation of the breakfast meal service being delivered to residents' rooms on 06/23/26 at 1:10pm revealed: -There were three plates of food on a cart and beverages. -There was no milk or other dairy on the cart. Interview with the resident on 06/23/26 at 1:25pm revealed: -She was not provided with milk to drink. -She liked milk and would drink milk if it was offered. Interview with a second resident on 06/23/26 at 1:32pm revealed: -The staff rarely brought him milk to drink. -He had not had milk in "a while". -He liked milk and would drink milk if it was offered. Interview with a cook on 06/24/26 at 10:47am revealed: -She did not know if milk had been offered to residents who ate in their rooms. -Milk should be offered to the residents who ate in their rooms.	D 299		

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D 299	Continued From page 29 Interview with the Dietary Manager (DM) on 06/24/26 at 1:08pm revealed that he expected milk to be offered to residents who ate their meals in their rooms. Interview with the Administrator on 06/24/26 at 2:44pm revealed milk should be offered at meals and snacks to residents who ate in their rooms. 2. Observation of the breakfast meal service in the dining room on 06/23/26 at 8:08am revealed: -There were 17 residents sitting in the dining room. -Each resident had one cup of liquid at their place setting. -No residents had a cup of milk at their place setting. -There was no milk in the dining room available to be served. Observation of the breakfast meal service in the dining room at various times on 06/24/26 between 7:45am 8:30am revealed: -There were 12 residents in the dining room and other residents were continually being brought into the dining room. -There was an opened gallon of 2% reduced fat milk in the dining room. -There was one resident eating a bowl of cereal with milk. -There was one resident with a bowl of dry cereal at his place setting; he had to request milk for his cereal. -No milk was offered to the residents as they were brought into the dining room. Interview with a resident on 06/23/26 at 8:54am revealed: -She ate her meals in the dining room. -She was only given milk when she ate cereal.	D 299		

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D 299	Continued From page 30 -She liked milk and would drink it if it was offered. -The residents were occasionally served ice cream, but not often. Interview with a second resident on 06/24/26 at 8:20am revealed: -He was not served or offered milk this morning for breakfast. -He only got milk when he was served cereal. -He liked milk and he would drink milk if it was served to him. -He had not asked the staff for any milk. -He did not start eating his cereal until he was given a glass of milk for his cereal. -The only time he received milk was with his cereal. Interview with a PCA on 06/24/26 at 10:17am revealed: -The cooks serve the milk -If a resident asked for milk, she would get it for them. Interview with the cook on 06/24/26 at 10:43am revealed: -She should offer milk to the residents in the dining room each meal. -She forgot to offer milk to the residents in the dining room that morning. -She was busy prepping and serving plates. Interview with the Dietary Manager (DA) on 06/24/26 at 1:06pm revealed: -Milk should be offered three times daily with meals and at snacks. -He did not know milk was not offered or served at meals -He expected milk to be offered at each meal. Interview with the Administrator on 06/24/26 at	D 299		

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D 299	Continued From page 31 2:42pm revealed: -Milk should be offered at each meal. -She expected milk to be offered at every 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 2 of 2 sampled residents (#1 and #4) who had an order for pureed meats. The findings are: 1. Review of Resident #4's current FL-2 dated 02/25/26 revealed diagnoses included atrial fibrillation, hypertension, and osteoarthritis. Review of Resident #4's current diet order dated 06/22/26 revealed there was an order for a regular diet with pureed meats. Review of the diet order list posted on the bulletin board in the kitchen revealed Resident #4 was to receive a pureed diet. Review of the pureed menu for the breakfast meal service on 06/23/26 revealed Resident #4 was to be served ½ cup fruit, 1 cup of cereal, 1	D 310		

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D 310	Continued From page 32 egg and sausage with gravy. Observation of the breakfast meal service on 06/23/26 at 8:15am revealed: -Resident #4 was served a scrambled egg, ground sausage, and oatmeal. -The food was not pureed. -She consumed 100% of her meal. -Resident #4 did not have any episodes of coughing during mealtime. Review of the pureed menu for the lunch meal service on 06/23/26 revealed Resident #6 was to be served oven fried chicken with sauce, 1 cup of cream of rice, ½ cup of green beans and a dinner roll or garlic bread. Observation of the lunch meal service on 06/23/26 at 1:00pm revealed: -Resident #4 was served chopped chicken, black-eyed peas, and collard greens. -The food was not pureed. -She consumed 100% of her meal. -Resident #4 did not have any episodes of coughing during mealtime. Review of the pureed menu for the breakfast meal service on 06/24/26 revealed Resident #4 was to be served 1/2 cup of assorted fruit, 1 cup of cereal, corned beef has with egg and English muffin. Observation of the breakfast meal service on 06/24/26 at 7:55am revealed: -Resident #4 was served corned beef hash, a boiled egg cut in half, and two English muffins. -The food was not pureed. -She consumed 100% of her meal. -Resident #4 did not have any episodes of coughing during mealtime.	D 310		

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D 310	Continued From page 33 Interview with Resident #4 on 06/24/26 at 1:30pm revealed: -She did not have any problems swallowing when she ate. -Sometimes she had a problem chewing because of her dentures. Interview with a personal care aide (PCA) on 06/24/26 at 10:17am revealed: -She knew Resident #4 was served pureed meats. -Resident #4 needed her food soft so she could chew it and swallow it easier. Interview with the cook on 06/23/26 at 8:32am revealed Resident #1 had an order for pureed meats with her meals. Interview with the cook on 06/24/26 at 8:24am and 1:38pm revealed: -She referred to the daily menu on the bulletin board when preparing the meals. -She did not have a weekly menu. -She referred to the dietary list when asked about the therapeutic menu. -Resident #4 had an order to pureed her meat. -She placed the meat in the blender with some broth to make it soft enough for Resident #4 to easily swallow. -She pureed the meat until it was smooth. -She did not puree Resident #4's breakfast meat this morning because it was already soft and "mushy" and easy for Resident #4 to swallow. Interview with the Dietary Manager (DM) on 06/24/26 at 1:08pm revealed that Resident #4's meat was not pureed in the photos. Interview with Resident Care Coordinator (RCC)	D 310		

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D 310	Continued From page 34 on 06/24/26 at 2:08pm revealed -Resident #4's meats should be similar to baby food once it was pureed. -It should be smooth, not chunky and not watery. -Resident #4 was having difficulty chewing her food and she was spitting pieces of meat out. -He spoke with the Primary Care Provider (PCP) and received an order for pureed meats. Interviewed with the Administrator on 06/24/26 at 2:42pm revealed: -Resident #4 had an order for pureed meats because she had difficulty chewing her food. -Resident #4's meats could be chopped because it was manageable for her to chew. -Resident #4 was not served pureed meats; the meat was thicker with chunks -Resident #4 had ground sausage for breakfast on 06/23/26, the chicken for lunch was ins chunks, and she was served corned beef hash for breakfast on 06/24/26, like the other residents. -Resident #4 needed the meats to be easier for her to chew. Attempted telephone interview with Resident #1's PCP on 06/24/26 at 4:15pm was unsuccessful. Refer to the interview with the DM on 06/24/26 at 9:51am and 1:08pm. 2. Review of Resident #1's current FL2 dated 04/24/26 revealed diagnoses included dementia, hypertension, and atrial fibrillation. Review of Resident #1's diet order dated 06/22/26 revealed an order for pureed meats. Observation of Resident #1's room on 06/23/26 at 8:27am revealed: -Resident #1 was in bed, asleep.	D 310		

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D 310	Continued From page 35 -A breakfast plate was left on her bedside table that included four sausage links, scrambled eggs, oatmeal, and a glass of orange juice. Observation of Resident #1's room on 06/23/26 at 8:32am revealed the breakfast meal had been removed from the bedside table; Resident #1 remained asleep. Observation of the dining room on 06/23/26 at 12:00pm revealed: -Resident #1 was sitting at the dining room table. -Her breakfast plate had been placed in front of her. -Her sausage links had been cut into bite-sized pieces. -Resident #1 was being encouraged to eat by staff members. -Resident #1 ate twenty-five percent of her breakfast. Observation of the lunch meal on 06/23/26 at 1:00pm revealed: -Resident #1 was served ground fried chicken, black-eyed peas, and turnip greens. -Resident #1 ate 1/2 of the ground fried chicken and 1/2 of the black-eyed peas. Interview with a personal care aide (PCA) on 06/24/26 at 10:29am revealed: -There was one named resident who was served a pureed diet; the named resident was not Resident #1. -There were other residents whose meats were ground up, so it was easier for the residents to eat and swallow. Interview with a cook on 06/24/26 at 10:47am revealed: -Resident #1 had an order for a mechanical soft	D 310		

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diet.
-The summer sausage served to Resident #1 on 06/23/26 at 12:00pm appeared to be cut up.
-The chicken served to Resident #1 on 06/23/26 at the lunch meal service did not appear to be pureed; it looked ground up.

Interview with the Dietary Manager (DM) on 06/24/26 at 1:08pm revealed that Resident #1's meat was not pureed in the photos

Interview with the Administrator on 06/24/26 at 2:44pm revealed:
On 06/23/26, there was only one resident who had an order for pureed meats.
-Resident #1's order for pureed meat was started today, 06/24/26.
-Resident #1's order for pureed meat was signed by the primary care provider (PCP) on 06/22/26 and should have been implemented on 06/23/26.
-Resident #1's meat looked chopped in the photograph provided.
-Resident #1's meat was changed to puree at her request, as the resident was not eating well, and she wanted to make sure the resident could easily eat and swallow her meat.

Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable.

Attempted telephone interview with Resident #1's PCP on 06/24/26 at 4:15pm was unsuccessful.

Refer to the interview with the DM on 06/24/26 at 9:51am and 1:08pm.

_____
Interviews with the DM on 06/24/26 at 9:51am and 1:08pm revealed:
-The cook did not know where the weekly or

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D 310	Continued From page 37 therapeutic menu was that morning when the surveyor asked her. -He typed the daily menus from the weekly menu and posted them on the bulletin board for a quick reference for the cooks. -The cooks know how to prepare pureed meats without using the therapeutic menu. -For a pureed diet, the meats should be cut up and pureed with vegetable broth to a smooth consistency. -He expected the residents to be served a pureed diet as ordered to prevent choking or for whatever reason the primary care provider (PCP) wrote the order for. -If he had noticed a resident was served meat that was not pureed correctly, he would take the item back to the kitchen and puree it correctly.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents requiring assistance with meals were assisted upon receipt of meals in a manner that was unhurried and were served with dignity and respect. The findings are:	D 312		

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D 312	Continued From page 38 Observation of the lunch meal on 06/23/26 at various times between 1:17pm and 1:42pm revealed: -A staff approached a resident sitting at the dining room table with his plate in front of him. -The staff picked up a piece of chicken from the residents plate with their bare hands. -The staff attempted to get the resident to bite the chicken off the bone; the resident turned his head. -The staff held the chicken with one hand while shredding the chicken from the bone with the residents fork. -The staff member pulled a chair up beside the resident and assisted with feeding the resident. -After a few bites, the staff got up and went to second resident and assisted her with a few bites of food; the staff member was not wearing gloves. -The staff returned to the first resident, picked up the chicken with her bare hands and fed it to him. -The staff continued to go between three residents assisting with encouraging them to eat and assisting with feeding them, using her bare hands, touching food and residents' silverware. -A second staff was standing and feeding a resident with her bare hands. -The second staff assisted two residents with encouraging and assisting with feeding, touching their silverware with ungloved hands. -A third staff entered the dining room and assisted a resident with feeding with ungloved hands. Observation of the breakfast meal on 06/24/26 at various times between 7:45am and 8:30am revealed: -A staff member breaks apart a residents english muffin with jelly into bites size pieces with gloved hands. -She feeds the resident a bite of the muffin with	D 312		

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jelly.
-The staff member moved to a second resident, picked up the resident's spoon and fed the second resident without changing her gloves or sanitizing her hands.
-The staff moved to a third resident and began feeding him, without changing her gloves or sanitizing her hands.
-The staff continued to go between three residents, assisting with feeding the residents, with the same gloves.
-The staff also touched dining room chairs and wiped a resident hands and mouth with a warm, moist towel.

Interview with a personal care aide (PCA) on 06/24/26 at 10:17am revealed:
-There are 2 or 3 staff members in the dining room at mealtime to assist with feeding residents.
-She makes sure the residents have enough to drink, gets them a warm, moist towel and cleans their mouth,
encourages them to eat, and feeds them when needed.
-One resident would set with his arms folded and he would not eat.
-She would get him started by feeding him a few bites and then she gave him the spoon to feed himself.
-There were other residents she would help feed when they stop eating; she wanted to make sure the residents ate.
-She broke food apart into smaller bites when needed.
-She had worked as an aide for 15 years; she did not remember any training on feeding residents.
-She forgot to wear gloves yesterday, 06/23/26, but she wore them today, 06/24/26, when she assisted residents with feeding.
-She typically would go back and forth from

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resident to resident to assist them with feeding and encourage them to eat.
-She knew she was to sit down with the resident when she fed them and to change gloves between residents.
-She forgot to get gloves yesterday and she did not have any in her pocket to use.

Interview with a medication aide (MA) on 06/24/26 at 1:55pm revealed:
-If the PCA needed assistance feeding residents she would help after she completed the medication pass.
-When feeding someone she needed to be sitting down, feed slowly, and wear gloves.
-She forgot to wear her gloves yesterday, but she wore them today.
-Cross contamination could occur if the same gloves were worn and hands were not washed when feeding multiple residents.

Interview with the Resident Care Coordinator (RCC) on 06/24/26 at 2:08pm revealed:
-Residents should be encouraged to feed themselves.
-If the residents do not feed themselves, the PCA should sit down and feed the resident
-The PCA should feed 1 residents at a time.
-The PCA should wear gloves when feeding residents.
-When the PCA assisted a second or third resident with feeding, the PCA should remove the gloves, wash hands and put on another pair of gloves.
-The PCA should not touch the resident's food with their bare hands.

Interviewed with the Administrator on 06/24/26 at 2:42pm revealed:
-Resident should be encouraged to self-feed.

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	HAL039018	A. BUILDING: _____ B. WING _____	R 06/24/2026

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TRE' MORE MANOR ALF	6016 PINE TOWN ROAD OXFORD, NC 27565

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D 312	Continued From page 41 -Staff should only feed one resident at a time to prevent cross contamination from one resident to another. -Staff should wear gloves when feeding residents. -Staff should sit down with one resident and finish the meal before moving on to another resident.	D 312		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 3 sampled residents (#1), including a medication used for mild to moderate pain. The findings are: Review of Resident #1's current FL2 dated 04/24/26 revealed: -Diagnoses included dementia, hypertension, and atrial fibrillation.	D 344		

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D 344	Continued From page 42 -There was an order for acetaminophen 500mg, take 2 tablets twice daily. Review of Resident #1's hospital discharge summary dated 06/03/26, time-stamped at 10:42am, revealed an order to stop taking acetaminophen 1000mg twice a day. Review of Resident #1's June 2026 electronic medication administration record (eMAR) from 06/03/26-06/23/26 revealed: -There was an entry for acetaminophen 500mg, take 2 tablets twice a day, scheduled at 8:00am and 8:00pm. -Acetaminophen was documented as administered from 06/03/26-06/23/26. Observation of Resident #1's medications on hand on 06/23/26 at 10:31am revealed: -There was a punch card of acetaminophen 500mg dispensed on 06/03/26 with instructions to take two tablets twice a day. -There were 27 of 30 doses remaining on the punch card. Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/23/26 at 11:39am revealed: -Resident #1's current order for acetaminophen 500mg, take two tablets twice daily, was originally ordered on 04/24/26. -One hundred twenty tablets of acetaminophen were dispensed on 05/14/26 and 06/02/26. -The hospital discharge summary received at the pharmacy was dated 06/03/26 and time-stamped 9:49am. -The discharge summary time-stamped at 10:42am would be considered the most recent discharge summary.	D 344		

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D 344	Continued From page 43 Telephone interview with Resident #1's primary care provider (PCP) on 06/23/26 at 3:00pm revealed: -She did not see any documentation Resident #1's acetaminophen order had been clarified. -If she had been asked about the acetaminophen order for Resident #1, she would have kept the resident on the acetaminophen. -She saw documentation that another PCP had reviewed the hospital discharge summary on 06/10/26 and had also documented the acetaminophen was discontinued. Interview with a medication aide (MA) on 06/24/26 at 1:55pm revealed: -She reviewed Resident 1's hospital discharge instructions when she returned to the facility. -She did not look at the medication orders; she was looking at the directions for her wound dressing. -She did not fax the hospital discharge orders to the pharmacy. Interview with the Resident Care Coordinator (RCC) on 06/24/26 at 2:06pm revealed: -He reviewed Resident #1's hospital discharge summary. -He did not see the order to discontinue Resident #1's acetaminophen. -A discharge summary was received prior to the resident returning to the facility and was faxed to the pharmacy. -When Resident #1 returned to the facility, she had a discharge summary with her, and he assumed it was the same as the one he had received earlier in the day. -If he had seen the order to discontinue the acetaminophen, he would have contacted the primary care provider (PCP) to have the order clarified since there were two different discharge	D 344		

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D 344	Continued From page 44 summaries. Interview with the Administrator on 06/24/26 at 2:44pm revealed: -She and the RCC review all discharge summaries. -The order for the acetaminophen should have been clarified if there were two different orders on the same day. -If she had seen two discharge summaries, she would have assumed they were the same. -Resident #1 was in a lot of pain and needed the dosage of acetaminophen.	D 344		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) who administered the medication was the same MA who signed the electronic medication administration records (eMAR) for 1 of 3 sampled residents (#1). The findings are:	D 366		

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D 366	Continued From page 45 1. Review of Resident #1's current FL2 dated 04/24/26 revealed: -Diagnoses included dementia, hypertension, and atrial fibrillation. -There was an order for tramadol (used to treat moderate to moderately severe pain) 50mg, take one tablet twice daily as needed. Review of Resident #1's hospital discharge summary dated 06/03/26 revealed an order for tramadol 50mg, take one tablet twice daily as needed. Review of Resident #1's signed physician's order dated 06/10/26 revealed an order for tramadol 50mg, take one tablet every 12 hours. Review of Resident #1's June 2026 eMAR from 06/03/26-06/23/26 revealed: -There was an entry for tramadol 50mg, take 1 tablet twice a day as needed. -There was a second entry for tramadol 50mg, take 1 tablet every 12 hours with a scheduled administration time of 8:00am and 8:00pm. -Tramadol 50mg was documented as administered by the Administrator 7 times from 06/10/26-06/23/26. Review of Resident #1's controlled substance count sheet (CSCS) for June 2026 revealed Resident #1 ' s tramadol was administered 7 times by a medication aide (MA) for the same dates the Administrator documented the administration on the eMAR. Telephone interview with a MA on 06/24/26 at 11:54am revealed: -She was hired 1.5 months ago and worked 7:00pm to 7:00am.	D 366		

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D 366	Continued From page 46 -She had taken the medication aide training course and the Administrator had checked her off to administer medications. -She administered medications during the evening hours that she worked. -She most recently administered medications last night, 06/23/26. -She did not have a sign in for the eMAR; she used the Administrators sign in on the eMAR when she administered medications. Interview with the Resident Care Coordinator (RCC) on 06/24/26 at 2:06pm revealed: -The signature/initials on the eMAR should be the same staff member who signed the CSCS. -The [named] MA who did not sign the eMAR should have signed in to be able to document on the eMAR. -He did not know why the MA had signed the CSCS and not the person who signed the eMAR. Interview with the Administrator on 06/24/26 at 2:44pm revealed: -The staff member who signed the CSCS when medications were administered should be the same person who signed the eMAR, except when a MA was training. -A MA who was being trained was not given login privileges on the eMAR and was signing off under her login. -She was not with the MA when the MA administered medications. -She knew the MA should have her own login so she could document her initials on the eMAR when medications were administered.	D 366		
D 367	10A NCAC 13F .1004 (j) Medication Administration	D 367		

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D 367	Continued From page 47 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure electronic medication administration records (eMAR) were accurate for 3 of 3 sampled residents (#1, #2, and #3) related to pain medications (#1 and #3) and two medications for anxiety (#2). The findings are: 1. Review of Resident #1's current FL2 dated 04/24/26 revealed: -Diagnoses included dementia, hypertension, and atrial fibrillation.	D 367		

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D 367	Continued From page 48 -There was an order for tramadol (used to treat moderate to moderately severe pain) 50mg, take one tablet twice daily as needed. Review of Resident #1's hospital discharge summary dated 06/03/26 revealed an order for tramadol 50mg, take one tablet twice daily as needed. Review of Resident #1's signed physician's order dated 06/10/26 revealed an order for tramadol 50mg, take one tablet every 12 hours. Review of Resident #1's May 2026 eMAR revealed: -There was an entry for tramadol 50mg, take 1 tablet twice a day as needed. -Tramadol 50mg was documented as administered 9 times. Review of Resident #1's controlled substance count sheet (CSCS) for May 2026 revealed Resident #1 was administered tramadol 18 times. Review of Resident #1's June 2026 eMAR from 06/03/26-06/23/26 revealed: -There was an entry for tramadol 50mg, take 1 tablet twice a day as needed. -Tramadol 50mg was documented as administered 8 times from 06/03/26-06/10/26. -There was a second entry for tramadol 50mg, take 1 tablet every 12 hours with a scheduled administration time of 8:00am and 8:00pm. -Tramadol 50mg was documented as administered 26 times from 06/10/26-06/23/26. -Tramadol 50mg was documented as administered a total of 35 times in June 2026. Review of Resident #1's CSCS for June 2026 revealed Resident #1 was administered tramadol	D 367		

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D 367	Continued From page 49 39 times. Observation of Resident #1's medications on hand on 06/23/26 at 10:31am revealed: -There was a punch card of tramadol 50mg dispensed on 06/10/26 with instructions to take one tablet twice a day. -There were 24 of 30 doses remaining on one punch card and 30 of 30 doses on the second punch card. Interview with a medication aide (MA) on 06/24/26 at 1:55pm revealed: -She used the computer to pull up Resident #1's tramadol. -She then looked at the CSCS to see when Resident #1's tramadol was last administered. -Once she administered Resident #1's tramadol, she documented the administration on the eMAR and the CSCS. -If there were doses of tramadol documented on the CSCS but not on the eMAR, it was because someone forgot to check off the administration on the eMAR. -The CSCS was the most important place to document the administration of Resident #1's tramadol, but staff needed to make sure they documented on both the eMAR and the CSCS. Refer to the interview with Resident Care Coordinator (RCC) on 06/24/26 at 2:08pm. Refer to the interviewed with the Administrator on 06/24/26 at 2:42pm. 2. Review of Resident #2's current FL-2 dated 04/07/26 revealed diagnoses included Alzheimer's disease with dementia, diabetes mellitus type 2, hypertensive disorder, hyperlipidemia and peripheral arterial disease.	D 367		

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D 367	Continued From page 50 Review of Resident #2's signed physician's order dated 04/27/26 revealed there was an order for lorazepam 0.5mg (used to treat anxiety and agitation) twice daily as needed for anxiety and agitation. Review of Resident #2's April 2026 eMAR from 04/29/26 to 04/30/26 revealed: -There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety/agitation. -There was documentation lorazepam was administered 1 time from 04/09/26 to 04/30/26. Review of Resident #2's May 2025 eMAR revealed: -There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety/agitation. -There was documentation lorazepam was administered 27 times from 05/01/26 to 05/31/26. Review of Resident #2's June 2026 eMAR from 06/01/26 to 06/22/26 revealed: -There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety/agitation. -There was documentation lorazepam was administered 17 times from 06/01/26 to 06/22/26. Review of Resident #2's controlled substance count sheet (CSCS) from April 2026 to June 2026 revealed Resident #2's lorazepam was documented 30 times as administered but was not documented on the eMAR. Interview with a medication aide (MA) on 06/24/26 at 12:15pm and 1:55pm revealed: -She signed the CSCS and the eMAR when she administered a controlled substance. -The eMAR had to be signed because she had to sign if the medication was effective.	D 367		

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D 367	Continued From page 51 -She did not realize she had forgotten to sign the eMAR a few times -The MA who administered the medication should be the one to document on the eMAR and the CSCS. Telephone interview with a second MA on 06/24/26 at 12:36pm revealed: -She signed the CSCS when she administered controlled substances -She did not sign the eMAR when she administered a controlled substance. -She did not know she was to sign the eMAR since she signed the CSCS. -No one had told her she needed to sign the CSCS and the eMAR when administering a controlled substance. Refer to the interview with Resident Care Coordinator (RCC) on 06/24/26 at 2:08pm. Refer to the interviewed with the Administrator on 06/24/26 at 2:42pm. 3. Review of Resident #3's current FL-2 dated 01/19/26 revealed diagnoses included muscle spasms, arthritis, insomnia, anxiety, and depression. Review of Resident #3 current FL-2 dated 01/19/26 revealed there was an order for oxycodone 5mg (used to treat pain) every 8 hours as needed for pain. Review of Resident #3's April 2026 eMAR revealed: -There was an entry for oxycodone 5mg every 8 hours as needed for pain. -There was documentation oxycodone was administered 28 times from 04/01/26 to 04/30/26.	D 367		

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D 367	Continued From page 52 Review of Resident #3's May 2025 eMAR revealed: -There was an entry for oxycodone 5mg every 8 hours as needed for pain. -There was documentation oxycodone was administered 24 times from 05/01/26 to 05/31/26. Review of Resident #3's June 2026 eMAR from 06/01/26 to 06/23/26 revealed: -There was an entry for oxycodone 5mg every 8 hours as needed for pain. -There was documentation oxycodone was administered 17 times from 06/01/26 to 06/23/26. Review of Resident #3's controlled substance count sheet (CSCS) from April 2026 to June 2026 revealed Resident #2's lorazepam was documented 20 times as administered but was not documented on the eMAR. Interview with Resident #3 on 06/24/26 at 10:05am revealed: -She took pain medications most days for joint pain and arthritic pain. -She asked the medication aide (MA) for the medication when she needed it. -Some days she only took one pill for pain and some days she took more than one pill a day. Interview with a MA on 06/24/26 at 12:15pm and 1:55pm revealed: -She signed the CSCS and the eMAR when she administered a controlled substance. -The eMAR had to be signed because she had to sign if the medication was effective. -She did not realize she had forgotten to sign the eMAR a few times -The MA who administered the medication should be the one to document on the eMAR and the	D 367		

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D 367	Continued From page 53 CSCS. Telephone interview with a second MA on 06/24/26 at 12:36pm revealed: -She signed the CSCS when she administered controlled substances -She did not sign the eMAR when she administered a controlled substance. -She did not know she was to sign the eMAR since she signed the CSCS. -No one had told her she needed to sign the CSCS and the eMAR when administering a controlled substance. Refer to the interview with Resident Care Coordinator (RCC) on 06/24/26 at 2:08pm. Refer to the interviewed with the Administrator on 06/24/26 at 2:42pm. _____ Interview with RCC on 06/24/26 at 2:08pm revealed: -The MAs should document in two places when administering a controlled substance; the CSCS and the eMAR. -He did not audit the CSCS against the eMAR to ensure all controlled substances were documented don the eMAR. -It was important to document on the CSCS to ensure accurate count of narcotics. -It was important to document on the eMAR to show the controlled substance administered to other resident. -If it was not documented on the eMAR the controlled substance could be given earlier than when it should. Interviewed with the Administrator on 06/24/26 at 2:42pm revealed: -When the MAs administer a controlled	D 367		

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D 367	Continued From page 54 substance, the MA should document on the CSCS as soon as the medication was prepared for medication. -The MA should document on the eMAR immediately after the medication was administered. -She did not know the MAs documented on the CSCS and not on the eMAR when administering controlled substances. -She had not compared the eMAR to the CSCS. -Her concern was that medications not documented as administered on the eMAR would not be accurately reflected for the PCP, who relied on the eMAR rather than the CSCS to determine how often medications had been administered.	D 367		