STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345194	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenflora	5701 Fayetteville Road Lumberton, NC 28360

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Nurse Practitioner, Medical Director, and Responsible Party interviews, the facility failed to provide ongoing assessments after a fall and failed to communicate effectively to provide medical diagnostics and treatment for 1 of 3 residents reviewed for assessment after a fall (Resident #1). Resident #1 was found on the floor mat beside her bed by Nurse #1 on 4/27/26 at approximately 4:30 AM. Nurse #1 stated Resident #1 did not have any apparent injury and she and Nursing Assistant (NA) #1 picked the resident up and placed her back in her bed. Nurse #1 did not report the fall to the oncoming nurse for the 7:00 AM to 7:00 PM shift, Nurse #2. Later, on 4/27/26, Nurse #2 observed an area on the front of Resident #1's left lower leg that was red, swollen and felt warm to touch. Nurse #2 contacted the Nurse Practitioner (NP) who ordered a study from their mobile x-ray company to rule out a blood clot in the leg. Nurse #2 reported the condition of Resident #1's leg to Nurse #3 when she came in for the 7:00 PM to 7:00 AM shift. Nurse #3 heard Resident #1 scream out on 4/28/26 at approximately 3:15 AM and Nursing Assistant (NA) #4 informed her Resident #1's leg was hurting. Nurse #3 observed Resident #1's left lower leg to have discoloration from above the ankle to below the knee and observed her foot was blue. When Nurse #3 lifted Resident #1's left leg, her left foot dangled and the bones in her lower leg appeared broken. Nurse #3 contacted the medical provider and received orders to send Resident #1 to the Emergency Department (ED). X-rays taken at the hospital on 4/28/26 revealed acute fractures of the left tibia and fibula (the 2 bones in the lower part of her leg, below the knee) with significant displacement (both bones in lower left leg were broken and the bones were moved out of alignment). Surgical repair was not an option and Resident #1 was admitted to the hospital for monitoring. The hospital Discharge summary dated [DATE] indicated Orthopedic surgery was consulted and Resident #1 underwent bedside splinting under sedation with plans to continue to keep her leg immobilized by continuing with the splint.Findings included:Resident #1 was admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, unspecified dementia, severe, with other behavioral disturbance, cognitive communication deficit, muscle weakness, lack of coordination, other abnormalities of gait and mobility, restless leg syndrome, severe protein-calorie malnutrition, and vitamin D deficiency.A review of Resident #1's annual Minimum Data Set (MDS), dated [DATE], revealed that Resident #1 was 1) moderately cognitively impaired, 2) had other behavioral symptoms not directed towards others that occurred 1-3 days, 3) had no impairment in her bilateral upper and lower extremities, 4) did not use a mobility device, 5) was dependent on staff for chair-bed-chair transfers, 6) was independent for rolling left and right in bed, sit to lying position in bed, and lying to sitting on side of the bed, 7) was dependent on staff for showers, toileting hygiene, putting on/taking off footwear, personal hygiene and oral hygiene, 8) required supervision or touch assistance with eating, 9) was frequently incontinent of her bowels and bladder, and 10) had one fall without injury since prior assessment.Resident #1's care plan, last revised on 3/10/26, revealed focuses of 1) impaired cognitive function/dementia or impaired thought processes related to dementia; 2) self-care and mobility performance deficit and indicated a) she required total staff assistance for her activities of daily living which included incontinence care and transfers, and b) required substantial assistance of staff with bed mobility due (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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NA #1 confirmed she worked on 4/26/26 from 11:00 PM to 7:00 AM on 4/27/26 and had been assigned to care for Resident #1. NA #1 explained she did not recall the time she heard Nurse #1 calling her to go to Resident #1's room and said she thought it had been somewhere between 2:00 AM and 4:00 AM. NA #1 explained that when she got to the resident's room, she saw Resident #1 lying on the floor, on top of the floor mat on the right side of her bed. She said that the resident was laying on the bottom structure of the bedside table with her knees curled up to her chest. NA #1 stated the resident did not look injured; she had been yelling a little bit but was not crying. NA #1 said that Nurse #1 instructed her to help her get the resident back in her bed and she did so by grabbing the resident under her arms while Nurse #1 supported her thighs and then the two of them placed Resident #1 back in her bed. NA #1 said the resident cried out when they picked her up and then did not hear her cry out any other time. NA #1 stated when they find a resident on the floor, they have to report it to the nurse and then it was the responsibility of the nurse to inform the Director of Nursing, the doctors and the residents' families. NA #1 said that Nurse #1 did not report the fall to anyone. NA #1 explained that Nurse #1 told her as they were walking out of the resident's room, don't tell a soul this happened, this stays between me and you. NA #1 said she was a little shocked the nurse said that to her but said they parted ways and said that she had no further conversations with Nurse #1 that shift. NA #1 said she returned to Resident #1's room around 4:00 AM when she started doing her rounds. She explained she provided incontinence care to the resident during which the resident did not cry out. NA #1 said she thought that the nurse was going to do what she was supposed to do, like filing an incident report, and said she found out the next day that the nurse did not do that. A telephone interview was conducted with Nurse #2 on 5/21/26 at 3:46 PM. Nurse #2 confirmed she had worked on 4/27/26 from 7:00 AM to 7:00 PM and had been assigned to care for Resident #1. Nurse #2 confirmed she had not received any information regarding Resident #1's fall earlier that morning during report from Nurse #1. She said that while she was getting report from Nurse #1, they could hear Resident #1 yelling and Nurse #1 told her that she started that, and Nurse #2 assumed the yelling was her usual yelling behavior. After report, Nurse #2 explained she went to Resident #1's room because the resident continued to yell. Nurse #2 explained Resident #1 had spasms in her legs from her restless leg syndrome often. She said she asked the resident if she was having spasms and hurting in her legs and said the resident said yes. She asked the resident if she would like some acetaminophen. Resident #1 did not respond to the question and Nurse #2 stated she administered the acetaminophen to the resident around 8:00 AM. Nurse #2 stated Resident #1 continued to yell off and on throughout the morning but that it was not continuous nor was it unusual for her to yell throughout the day. She said she went and checked on Resident #1 around lunch time and observed the resident grabbing at her left leg. Nurse #2 said she looked at the resident's leg and saw nothing on her leg to indicate any injury. Around 3:00 PM, she went back to Resident #1's room to administer her scheduled medications through her gastrostomy tube (g-tube) and when she turned on the lights in the room, she observed an area on the front of the resident's left lower leg below the knee but above the ankle that appeared red, swollen and felt warm to touch. Nurse #2 stated that the resident was not yelling during that time. She explained that she has known this resident since she had been admitted to the facility and was familiar with her behaviors, like yelling all the time. She also said that sometimes Resident #1 would respond appropriately to questions and could voice her (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	needs at times, but at other times she would not do that. She said she asked Resident #1 if she had hit her leg on anything and the resident did not respond. After she left the resident's room, Nurse #1 said she called the Nurse Practitioner (NP) to tell her about the resident's leg and said the NP asked her if the resident had hurt her leg, and she said she told the NP there had been no injury. She questioned whether the resident might have a clot in a vein and voiced her concern to the NP. She stated the NP ordered a doppler (a common test used to look for blood clots in veins; it uses sound waves to look at veins and the blood flowing through them) from their mobile x-ray company. Nurse #1 stated that at some point, the resident's yelling tapered off and when her shift ended, she explained to the oncoming nurse, Nurse # 3, what had been going on with Resident #1 throughout the day. When she returned to work the following morning, Nurse #3 informed her that Resident #1 had been taken to the hospital where it was discovered she had fractures in her leg.Review of the Medication Administration Record indicated Resident #1 had an order for acetaminophen 325 milligrams (mg) 2 tabs via g-tube (gastrostomy tube) as needed for general discomfort. Nurse #2 administered a dose of acetaminophen on 4/27/26 at 7:54 AM. Record review revealed a communication progress note to physician written by Nurse #2 on 4/27/26 at 3:43 PM. It read, Situation: discolored LLE [left lower extremity]; Background: reoccurring complaints of cramps; Assessment: resident observed with lower left extremity discolored, slightly swollen and warm; Recommendations: one time order for left lower venous doppler.A late entry progress note dated 4/27/26 at 5:30 PM, written by Nurse #2, read, During morning report resident noted hollering out. Night nurse reported she has started ?that'. Note resident has times when she hollers out. After [7:30 AM] nurse went into residents' room to administer morning medications. While in room resident rolling around in bed. grabbed her left leg and hollered. Nurse asked resident if she was having leg cramps and resident stated ?yes'. Nurse asked resident if she wanted some Tylenol, resident stated ?yes'. Nurse asked MT [medication technician] to crush Tylenol d/t [due to] resident showing signs of pain. Noted resident hollered off and on during shift. Approximately after [3:30 PM] this nurse went into room to administer meds and flush. when entering room I cut on the light in room As I was walking towards residents' bed I observed left leg discoloration (redness). I asked resident what happen to her leg and if she was still having cramps. Resident shook her head no. I administered meds and flush. Assessed LLE. Noted it to be discolored (redness) warm to touch and slightly swollen. Nurse notified [name of nurse practitioner] at approximately [3:43 PM] of assessment of LLE and previous complaints of pain/cramps during the shift. [Name of nurse practitioner] gave stat order for LLE venous doppler.A telephone interview was conducted with the facility's Nurse Practitioner (NP) on 5/22/26 at 12:36 PM. The NP explained that Nurse #2 had called her 4/27/26 and informed her how Resident #1 had slight discomfort in an area in the front of her left lower leg and that the area was warm and tender to touch. She stated that at that time, she did not know the resident had fallen. Since she presented with signs and symptoms of a deep vein thrombosis (a clot in a vein), the NP stated she ordered a doppler using the facility's mobile x-ray company. The NP explained that she had been seeing the resident since December 2025 and that she had been bedbound for two years. She said she had been unaware of the condition of Resident #1's bones until she went to the hospital and had x-rays. The NP explained that Resident #1 had falls in the past that resulted from the resident's attempts to get up out of bed. She further explained that the resident's chances for fractures were increased as compared to regular people secondary to her having been bedbound for so long, having protein malnutrition, and her diagnosis of failure to thrive. She stated Resident #1 was on hospice. The NP indicated these conditions as well as the condition of her bones would have made the fractures worse. The NP also stated by Nurse #1 not reporting the fall to anyone caused a delay in the diagnosis and therefore the care Resident #1 required.A telephone interview was conducted with NA #2 on 5/28/26 at 9:15 AM. NA #2 confirmed she worked on 4/27/26 from 7:00 AM to 3:00 PM and had been assigned to care for Resident #1. NA #2 explained that the nurse aides do not give each other report at the beginning of the shift like the nurses do. She stated she first saw Resident #1 around 7:15 AM and that she had been asleep and (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	there was nothing out of the ordinary. NA #2 stated she saw her again when she went in to provide morning care to the resident around 9:15 AM. She said she observed Resident #1's leg during the bed bath and thought everything looked normal. She said the resident turned from side to side in the bed and did not grimace or yell out. Around 11:00 AM, she brought her some ice cream, and she got it all over herself and NA #2 said she had to clean her up and again showed no signs of being in pain. NA #2 explained Resident #1 would often yell out and she would go check on her and ask her if she was in pain, or if she needed the nurse, and said the resident would say no. She said the last time she checked on her was right before the end of the shift, right before 3:00 PM, and Resident #1 was not acting like she was in any pain. NA #1 said when she came in the next morning on 4/28/26, she was shocked to find out the resident had been sent out to the hospital through the night and had a broken leg.Multiple attempts to conduct a telephone interview with NA #3, who worked on 4/27/26 from 3:00 PM to 11:00 PM and had been assigned to care for Resident #1, were unsuccessful.The facility provided NA #3's statement, as told to the Administrator during a telephone interview with NA #3 on 4/30/26. It read as follows: States resident was unusually quiet and sleeping a lot during the shift. States the resident is normally awake and asking for water. She states she did not see the discoloration of the left leg until around 9:45 PM. Around 10:30 [PM], another CNA [certified nursing assistant] notified her that resident had black substance in g-tube and nurse [name of Nurse #3] was aware and in the room working on the issue with g-tube. She states she is unaware of anything else.A telephone interview was conducted with NA #4 on 5/27/26 at 12:26 PM. NA #4 confirmed that she worked on 4/27/26 from 11:00 PM to 7:00 AM on 4/28/26 and had been assigned to care for Resident #1. She explained that she first saw Resident #1 when she had been making her first rounds of the night around 11:00 PM. NA #4 stated that when she provided incontinent care to the resident, she noticed Resident #1's left leg was a little red but said that the resident was still moving her leg and did not yell out during care. She explained she saw the resident again during her second rounds of the night, around 2:30 AM. She stated that when she changed the resident's adult brief was when she started complaining of pain in her left leg. She said Resident #1 laid on her back and held her leg towards her chest. NA #4 said she asked the resident if her leg was hurting and if anyone had looked at it. She said Resident #1 told her that someone had looked at it during the day. NA #4 said that was when she left to get Nurse #3. It was sometime after that NA #3 said she heard the resident scream out but said that was not unusual because she yelled all the time. NA #4 stated she told Nurse #3 about the resident's leg pain and said did not return to the resident's room because Nurse #3 and Nurse #4 were in there and that was when everything started happening and Resident #1 got sent out. A telephone interview was conducted with Nurse #3 on 5/27/26 at 12:02 PM. Nurse #3 confirmed that she worked on 4/27/26 from 7:00 PM to 7:00 AM on 4/28/26 and had been assigned to care for Resident #1. She stated that Nurse #2 had reported to her that Resident #1 had a swollen, red, and tender-to-touch left lower leg. She had also told her that a doppler had been ordered but had not been done yet. Nurse #3 said she first saw the resident when she went into her room between 7:45 PM and 8:00 PM. She said she had some concerns with residuals from the resident's g-tube and continued to check on her regarding that matter. She stated that around 3:15 AM on 4/28/26, she heard Resident #1 scream very loudly and NA #4 came to her and said that the resident was complaining that her leg was hurting. Nurse #3 explained that she pulled some acetaminophen to give her and went to the resident's room. When she assessed her, Nurse #3 stated the resident had a lot of discoloration in her left lower leg from right above her ankle and all the way to her knee. She observed her left foot to be blue in color like there was no circulation going to it, and when she put her hand under the lower part of the leg to lift it off the bed, Resident #1's foot just dangled and her leg looked obviously broken at that time. Nurse #3 stated she called for Nurse #4 to come to the room to help her splint the leg with gauze. She stated at that time, she called the hospice nurse who asked her if she needed to come to the facility and Nurse #3 stated no, that she was sending Resident #1 out to the hospital and the hospice nurse agreed. Nurse #3 stated she called Emergency Medical Services (EMS). When EMS (continued on next page)

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Glenflora	5701 Fayetteville Road Lumberton, NC 28360

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	DON to inform her what was going on. Nurse #4 added that they fired her and said she thought it was because they thought she knew more than she actually did.Review of the Emergency Department (ED) records, dated 4/28/26, revealed that Resident #1 presented to the ED with complaints of left lower leg pain. The Physician Assistant (PA) indicated some of the resident's history had been provided by a family member who had explained that Resident #1 had been bedbound for at least 2.5 years and that she rarely got up out of bed in a wheelchair. A Medical Doctor (MD) who also saw the resident in the ED stated that an x-ray of her left tibia and fibula revealed acute fractures of the bones with significant displacement. The x-ray also revealed that Resident #1 had osseous demineralization (bones appeared weakened overall from things such as aging and lack of weight-bearing activity like being bedbound and these factors can make the bones more susceptible to breaking). The PA noted that because Resident #1 had not been out of bed in more than 2.5 years, it was highly likely that her bone quality is very weak and could not be surgically repaired the usual way as her bones would not hold pins and screws. She also stated that a surgical repair would not restore ambulation because she had not walked for years and therefore surgical repair was not an option. Resident #1 had been admitted to the hospital for monitoring with plans to continue to keep her leg immobilized by continuing with the splint that Emergency Medical Services (EMS) had placed on it prior to transporting her to the hospital from the facility. The MD noted that Resident #1 was evaluated by an orthopedic team while in the ED and recommended conservative management with splinting of the fracture injury and placing a hard cast likely the following day. A review of Resident #1's hospital Discharge summary, dated [DATE], revealed the resident's primary discharge diagnosis was a comminuted fracture (type of bone break in which the bone shatters or splits into three or more pieces) of the left tibia and fibula. During her hospitalization, orthopedic surgery was consulted and the patient underwent bedside splinting under sedation. The discharge summary indicated that given her advanced age and multiple comorbidities (additional co-existing illnesses) she had not been a candidate for surgical repair. At the time of her discharge, she was stable with well-controlled pain and stable fracture immobilization. The note stated she would be discharged back to the facility with plans for continued conservative orthopedic management, completion of antibiotic therapy, and close outpatient follow-up. During an interview with the Director of Nursing (DON) on 5/27/26 at 11:21 AM, the DON stated their investigation began as soon as they found out about Resident #1's fractures. The DON explained that on 4/27/26 Nurse #2 had informed her about Resident #1's leg being warm and tender-to-touch and that a doppler had been ordered. It had been on 4/28/26 when Nurse #3 called her and said that something was going on with the resident's leg, that it was deformed looking. She said they began to interview staff and an interview of NA #1 by their Clinical Nurse Consultant revealed some information that led them to the discovery of Resident #1's fall. She stated they eventually spoke with Nurse #1 who denied knowledge of anything that could have happened to Resident #1, saying that she went into her room so many times and that the resident had told her to shut up. The DON said she and the Administrator informed her about the resident's fractures and placed her on suspension. She said it was then that Nurse #1 opened up and explained to them how she found the resident lying on the floor and how she and NA #1 had picked her up and placed her back in the bed. She continued and said that Nurse #1 denied instructing NA #1 not to say anything about Resident #1's fall but then later stated she had instructed her not to tell anyone about the resident's fall. When asked why she thought the nurse did not inform anyone of Resident #1's fall, the DON said she can only state what Nurse #1 told them - that the resident's fall was around 5:30 AM, around the start of her medication pass time and towards the end of her shift. She said the nurse told them that she had something to do when she