STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamance Health Care Center	1987 Hilton Road Burlington, NC 27217

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, resident interviews, significant other interview, and staff interviews, the facility failed to ensure the provision and availability of linens to meet the hygiene and comfort needs for 9 of 9 residents representing three of four halls and interviewed regarding linen availability (Residents #4, #12, #10, #13, #14, #15, #16's significant other, #17, and #18).Findings included:a. Record review revealed Resident #4 had a Medicare 5-day Minimum Data Set assessment dated [DATE] which coded her as cognitively intact.An interview was conducted with Resident #4 on 6/22/2026 at 8:09 AM who resided in Mauve one hall. Resident #4 stated that both nurse aides and nurses told her they did not have washcloths or towels. She reported that staff attempted to bathe her daily, but due to the lack of linens, they used one end of a towel to bathe her and the other end to dry her because there were not enough towels available.b. Record review revealed Resident #12 had a significant change Minimum Data Set assessment dated [DATE] which coded her as cognitively intact.Resident #12, who resided in Mauve one hall, was interviewed on 6/22/2026 at 8:50 AM. Resident #12 stated she was unable to receive a bed bath when the facility did not have sufficient linen and reported that the facility frequently did not have enough linen available.c. Record review revealed Resident #10 had a quarterly Minimum Data Set assessment dated [DATE] which coded her as cognitively intact.Resident #10, who resided in Mauve one hall, was interviewed on 6/22/2026 at 8:38 AM. Resident #10 stated there were no towels or washcloths available that morning and that residents would not receive washups or showers until later in the day. Resident #10 also reported that there was nobody in the laundry room to run the laundry machines that morning.d. Record review revealed Resident #13 had a quarterly Minimum Data Set assessment dated [DATE] which coded him as cognitively intact.Resident #13, who resided in Mauve one hall, was interviewed on 6/22/2026 at 9:13 AM. Resident #13 stated there frequently were no washcloths or towels available in the mornings. Resident #13 stated he wiped himself down with wipes that morning due to the lack of clean washcloths and towels.e. Record review revealed Resident #14 had a Medicare 5-day Minimum Data Set assessment dated [DATE] which coded her as cognitively intact.On 6/22/2026 at 9:44 AM, an observation and interview were conducted with Resident #14, who resided in Mauve one hall. Resident #14 stated she had to use bibs to wash up in the bathroom when no towels or washcloths were available. She stated she did not use soiled bibs, but at times they were the only item available. Resident #14 held up a clothing protector (bib) and stated that was what she planned to use to clean herself that day. She stated the lack of towels and washcloths bothered her but not enough for her to report it to staff.f. Record review revealed Resident #15 had a quarterly Minimum Data Set assessment which coded her as cognitively intact.Resident #15, who resided in Mauve two hall, was interviewed on 6/22/2026 at 10:02 AM. Resident #15 stated her biggest complaint was that in the morning the facility may or may not have any linen. She stated she held on to towels when she had them in case, she needed one later. Resident #15 stated that her nurse aides often searched other halls to locate a pad or sheet for her when none were available in her own hall.g. Record review revealed Resident #16 had a quarterly Minimum Data Set assessment dated [DATE] which coded her (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as having moderately impaired cognition.On 6/22/2026 at 10:33 AM, an interview was conducted with the significant other of Resident #16, who was also her emergency contact. Resident #16 resided in Mauve one hall. He stated he visited frequently and washed Resident #16's laundry himself because linens in the facility had just disappeared. He reported bringing in packages of washcloths for Resident #16's personal use due to the lack of facility-provided washcloths.h. Record review revealed Resident #17 had a quarterly Minimum Data Set assessment dated [DATE] which coded her as cognitively intact.Resident #17, who resided in Teal Hall, was interviewed on 6/22/2026 at 11:19 AM. Resident #17 stated she was lying on two pillowcases on top of a pad because the laundry did not have any clean sheets that morning. Resident #17 was observed to have a sheet on her mattress, an incontinence pad, and two pillowcases on top of the pad at the time of the interview. She stated that at 10:00 AM, when Hospice attempted to bathe her, there were no clean sheets available. She also stated that at times there were no clean gowns available depending on the time of day.i. Record review revealed Resident #18 had an annual Minimum Data Set assessment dated [DATE] which coded him as cognitively intact.Resident #18, who resided in Teal Hall, was interviewed on 6/22/2026 at 11:52 AM. Resident #18 stated he had been waiting all morning for a washcloth and towel so he could bathe himself. He stated that sometimes there were no sheets, but that morning there were no washcloths or towels. Immediately following the interview, at 11:55 AM, the linen cart outside Resident #18's room was observed, and it contained no washcloths or towels and one folded sheet.Nurse Aide (NA) #4 was interviewed on 6/22/2026 at 9:23 AM. NA #4, who worked the 7:00 AM to 7:00 PM shift in the Mauve one hall, stated there were no linens, washcloths, or towels available. She stated she went to the laundry room and found no staff present and no linens. NA #4 stated she would have to use wipes until laundry was completed and that baths and showers would not be provided until later in the shift. NA #5 was interviewed on 6/22/2026 at 9:32 AM. NA #5, who worked the 7:00 AM to 7:00 PM shift in the Mauve one hall, stated there were currently no clean washcloths or towels available. She stated she had to prioritize which residents received linens based on therapy schedules or appointments. She stated additional linens might be available between 2:00 PM and 3:00 PM and that she had voiced concerns about linen shortages in the past, but nothing had changed. NA #6 was interviewed on 6/22/2026 at 9:56 AM. NA #6 stated she had worked the 7:00 PM to 7:00 AM shift and was working a 16ˆhour shift that day in the Mauve two hall. She stated she was able to give four bed baths that morning but that there were currently no towels or washcloths available, and she was waiting for laundry to be completed before continuing. An observation and interview were conducted with the Environmental Services Director on 6/23/2026 beginning at 2:40 PM. The Director stated that as of 6/1/2026, the environmental services department was no longer contracted, and staff were employed by the facility. She reported three laundry shifts: 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM, and 10:00 PM to 6:00 AM. She stated that on 6/22/2026, a laundry aide called out, and she could not arrive until 8:23 AM to cover the shift. She stated laundry did not reach the hallways until around 9:20 AM and that even one missed hour affects the entire laundry production cycle. Observations were made at the time of the interview of the laundry department shelves and the locked backup laundry storage room. The Director stated only she and the Maintenance Director had a key to the backup room. She acknowledged she had removed the last of the facility's supply of washcloths on 6/22/2026 and on the morning of 6/23/2026. She stated she was only able to order more washcloths at the end of the month and was still learning required quantities and budgeting. The Director reported she was unaware of any resident concerns with not having enough washcloths, towels, or linens. The Administrator was interviewed on 6/24/2026 at 8:18 AM. The Administrator stated it was her expectation that linens be kept at par levels according to the building census. She reported that the Environmental Services Director did not need to wait until the end of the month to order washcloths if supplies were needed.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure staff implemented the facility's abuse reporting and protection policy and procedures by failing to immediately report to the Administrator leading to a lack of protection after an allegation of staff^to^resident physical abuse involving Nurse #1 and Resident #3. This failure affected one of three residents that were reviewed for implementation of abuse policies and procedures (Resident #3).Findings included:Review of the facility's policy titled Abuse/Neglect/Misappropriation/Crime, effective 10/17/2024, under Patient Protection, stated: All employees are responsible for immediately (no later than two hours after the allegation is made if the incident involves abuse or bodily injury) reporting to the Administrator, or in their absence, the Director of Nursing, or their immediate supervisor, any and all suspected or witnessed incidents of patient abuse, neglect, theft, exploitation, and/or mistreatment of a patient as well as any reasonable suspicion of a crime against a patient. Review of the same policy and procedures under Reporting Requirements/Investigations, stated documentation in the investigation must include that immediate action was taken to protect the patient from further injury.Resident #3 was admitted on [DATE] with cumulative diagnoses including Parkinson's disease with dyskinesia, hemiplegia, hemiparesis, anxiety disorder, schizophrenia, intellectual disabilities, and major depressive disorder.Review of a facility^reported intake dated 5/26/2026 revealed that Nurse Aide (NA) #1 reported Nurse #1 had physically abused Resident #3 in the hallway. NA #1 acknowledged she learned of the allegation approximately one week prior, but the facility had not been informed at the time of the alleged incident. The facility reported intake noted that protection of Resident #3 began with the suspension of Nurse #1 on 5/26/2026 after the abuse allegation was reported to the Administrator. An interview with NA #1 on 6/23/2026 at 5:00 PM revealed her scheduled hours were 7:00 PM to 7:00 AM. NA #1 stated Nurse #1 was known to intimidate Resident #3 due to the resident's behavior of walking the halls late at night seeking food. NA #1 stated she did not previously report concerns regarding Nurse #1 because she believed staff would not believe her and had been told Nurse #1 was an asset for consistently working nights and picking up extra shifts. NA #1 reported that on 5/25/2026 she was written up and sent home by Nurse #1 for eating in the day room. Later that evening, NA #2 sent her four photographs depicting Nurse #1's right hand on the back of Resident #3's neck and going down the hallway, to use as evidence against Nurse #1. NA #1 recognized the actions in the photographs as abuse but stated she did not know when the photographs had been taken. On the morning of 5/26/2026 at approximately 10:30 AM, NA #1 met with the Administrator and Director of Nursing and provided the photographs sent to her by NA #2. NA #1 reported she was suspended and ultimately terminated after coming forward.Attempts to contact NA #2 by telephone and text were unsuccessful.An interview with NA #3 on 6/22/2026 at 2:53 PM revealed her usual hours were also 7:00 PM to 7:00 AM. NA #3 reported witnessing several occasions where Nurse #1 pulled Resident #3 down the hallway to his room. NA #3 specifically described an incident in February 2026 at approximately 12:30 PM where she observed Nurse #1 dragging Resident #3 by the neck down the hallway. NA #3 did not report the incident because she believed Nurse #1 was a respected employee and feared retaliation or suspension. NA #3 reported she was terminated from the facility on 5/29/2026 after revealing her knowledge of the alleged abuse.An interview was conducted with Nurse #2 on 6/22/2026 at 4:19 PM. Nurse #2 reported she had started working the 7:00 PM to 7:00 AM shift beginning in March or April 2026. She further reported she worked consistently from the same nursing station as Nurse #1 on the same shift in May 2026 until 5/26/2026 when she was notified Nurse #1 was suspended. Nurse #2 confirmed Nurse #1 was assigned to the hallway Resident #3 resided during May 2026. An interview with the Assistant Director of Nursing (ADON) on 6/23/2026 at 3:09 PM confirmed the facility was not made aware of the abuse allegation involving Nurse #1 and Resident #3 until 5/26/2026 when NA #1 was interviewed. The ADON stated that NA #2 told her in an interview (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the photographs had been taken in February 2026 and that he had submitted them to the corporate compliance phone line. The ADON stated that the corporate phone line could not receive photographs via a text message, so the compliance phone line did not receive the photographs from NA #2 in February 2026. NA #2 also confirmed he shared the photographs with NA #1. An interview with the Administrator on 6/24/2026 at 4:24 PM revealed the Administrator expected the abuse policies and procedures to be followed and all abuse allegations to be reported to her or the Director of Nursing immediately.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family interview, nurse practitioner interviews, and staff interviews, the facility failed to ensure accurate documentation of a medical diagnosis for one of three residents reviewed for the accuracy of medical record documentation (Resident #4).The findings included:Resident #4 was admitted to the facility on [DATE] with cumulative diagnoses including coronary artery disease, myocardial injury, hypertension, Type 2 diabetes mellitus, congestive heart failure, and chronic kidney disease.Record Review of the electronic medical record revealed the principal admitting diagnosis listed for Resident #4 was Parkinson's disease, entered on 5/6/2026 by Minimum Data Set (MDS) Nurse #1. This diagnosis represented an acute neurological condition not supported by the resident's documented medical history.Record review of follow-up notes dated 5/13/2026, 5/14/2026, and 5/17/2026 written by NP #1 revealed that the diagnosis of Parkinson's disease first appeared in NP #1's documentation on 5/14/2026 for Resident #4. Subsequent documentation in progress notes after 5/14/2026 by NP #1 listed Parkinson's disease as a diagnosis for Resident #4.A telephone interview was conducted with a family member of Resident #4 on 6/22/2026 at 1:34 PM. The family member reported that Resident #4 was scheduled for discharge to another skilled nursing facility on 6/12/2026. Upon arrival, the receiving facility refused admission because the transfer documents listed a diagnosis of Parkinson's disease. The family member stated she informed the receiving facility that Resident #4 did not have Parkinson's disease; however, due to the incorrect documentation, the resident was denied admission and returned to the originating facility.An interview was conducted with MDS Nurse #1 on 6/23/2026 at 11:01 AM. MDS Nurse #1 stated she utilized a web-based software platform designed to identify potentially relevant clinical information for MDS assessments. She reported receiving an alert that new documentation, such as orders, hospital records, or progress notes, might affect reimbursement for the MDS look-back period for Resident #4. MDS Nurse #1 stated that after reviewing the electronic medical record, she added Parkinson's disease as a diagnosis on 5/6/2026 and documented that her source was a follow^up note dated 4/21/2026 written by Nurse Practitioner (NP) #2.A telephone interview was conducted with NP #2 on 6/24/2026 at 11:53 AM. NP #2 confirmed that Resident #4 was not admitted from the hospital with a diagnosis of Parkinson's disease. NP #2 acknowledged that she mistakenly entered Parkinson's disease in her 4/21/2026 follow-up note. NP #2 stated she was unsure how the error occurred and speculated it may have resulted from an Artificial Intelligence (AI) dictation suggestion based on the resident's symptoms, but she confirmed it was an incorrect entry requiring correction.An interview was conducted with NP #1 on 6/23/2026 at 11:01 AM. After reviewing her notes, NP #1 acknowledged that Parkinson's disease was included in her documentation without explanation or verification. NP #1 stated that she does not independently add diagnoses such as Parkinson's disease, as a neurology evaluation would be required. NP #1 reported that an AI program was used to review resident documentation for completeness and that it was possible the program generated an erroneous diagnosis by analyzing hospital records, symptoms, and medications. NP #1 stated that documentation from her prior notes, including diagnoses, was pulled forward automatically into subsequent notes. She reported having identified previous AI^related documentation errors in other resident charts. NP #1 acknowledged that she signed, dated, and time^stamped her notes for accuracy and was responsible for reviewing the entire note to ensure accuracy when AI^generated suggestions were included.An interview with the Administrator was conducted on 6/24/2026 at 8:18 AM. The Administrator stated it was her expectation that all resident documentation be accurate.