STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0517	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fleshers Fairview Health Care	**3016 Cane Creek Road , Fairview, North Carolina, 28730**

(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) COMPLETION DATE
L0000	INITIAL COMMENTS A complaint survey was conducted from 9/15/25 through 9/22/25. Event ID# 1D7A8B-H1. The following intakes was investigated 803196. 1 of 1 complaint allegation resulted in a deficiency.	L0000		10/20/2025
L0035	PATIENT RIGHTS CFR(s): .2207 10A-13D.2207 (a) The facility shall enforce the Nursing Facility Patient's Bill of Rights as described in G.S. 131E-115 through G.S. 131E-127. (b) In matters of patient abuse, neglect or misappropriation the definitions shall have the meaning defined in Rule .2001 of this Subchapter. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to protect a resident's right to be free from abuse for 1 of 3 (Resident #40) reviewed for physical abuse. The findings included: Resident #40 was admitted to an adult care home bed on 2/21/23. Resident #40 was admitted to a nursing home bed on 1/31/25 with diagnoses which included unspecified dementia.	L0035	All residents have the right to be free from physical abuse. An in-house investigation was completed on the allegation of abuse. This investigation was completed on 12/17/2024. The facility became aware of the allegation on 12/12/24. This allegation was reported to NCDHHS with the initial investigation report being sent on 12/12/24. The staff member that was alleged with abuse was immediately suspended from work on 12/12/24 pending investigation for the protection of other residents. The CNA that reported abuse states that it happened on 12/10/25. Director of nursing provided extensive education to this CNA on her duty to report any and all suspected resident abuse to a direct supervisor immediately. During this CNA's interview she stated that resident had fecal matter on her hands and her hands in her brief. CNA states that other Nurse Aide slapped resident's hand and mocked her. DON conducted an interview with TNA accused of abuse. Her statement was that the resident had her hands folded up in her shirt, and that she has smeared fecal matter into her shirt. Nurse Aide states that she did ask resident not to "play in her stool" but that she never made physical contact with her. Upon report of abuse, ADON completed assessment of resident on 12/12/25 which showed no indication of abuse including bruising. DON interviewed other staff members as well during investigation. Resident was unable to give a statement. Due to the only two witnesses in the room having conflicting statements, the investigation of abuse was unsubstantiated. After the investigation, the Administrator received letter confirmation from a representative from NCDHHS that they would not conduct an investigation on the case.	09/23/2025

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

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L0035	Continued from page 1 Resident #40's quarterly Minimum Data Set dated 8/01/25 indicated she had modified independence for decision making with some difficulty in new situations only. She was coded as dependent on staff for dressing and hygiene. She was coded as no rejection of care. Resident #40's care plan revised on 2/12/25 had a focus related to thought processes impaired related to dementia, anxiety and depression. Interventions included offer verbal reassurance to resident and talk to resident during care. Resident #40 was not interviewable. Review of the Initial Allegation Report fax dated 12/12/24 at 3:28 PM revealed the following allegation information: - Allegation/incident type – resident abuse - incident date of 12/10/24 - date facility became aware of incident 12/12/24 - time facility became aware of incident 2:00 PM The Initial Allegation Report allegation details read that the incident was reported by Nursing Assistant (NA) #7 that Nursing Assistant (NA) #8 smacked Resident #40 on the hand during personal care and mocked her. The details of physical or mental injury or harm were none apparent. Review of the Investigation Report fax dated 12/17/24 at 11:01 PM read to see attached for summary of facility investigation. The attachment dated 12/12/24 was signed by the Director of Nursing (DON). It read in part that it was brought to her attention on December 12, 2024, by NA #7 that an incident had occurred on December 10, 2024 involving NA #8 and Resident #40. The Assistant Director of Nursing (ADON) immediately went and performed a skin assessment on Resident #40 which was unremarkable for any bruising or abrasions and a resident interview was conducted with her, but she was unable to recall the occurrence. Resident #40 has a primary diagnosis of Alzheimer's Disease with a BIMS (Brief Interview for Mental Status) of 0/15. Follow-up skin checks have been conducted each day since the initial allegation and remain unremarkable. NA #8 was contacted via telephone to discuss the incident. NA #8 stated that on 12/10/24, she and NA #7 were in Resident #40's room beginning to provide peri-care when they realized the resident had a bowel movement. NA #8 then	L0035	Continued from page 1 In person training was completed by the Director of Nursing starting on 6/2/25 to all nursing staff on how to properly care for a resident that is exhibiting difficult behaviors. Online training was also assigned on 6/3/25 to all staff in every department on identifying and reporting abuse and neglect. Education included timely reporting. Online training also included a post test that staff had receive a passing score of 80% to be marked as completed. This training on identifying and reporting, as well as residents rights (which includes abuse training), has been added to new hire orientation as well as yearly orientation that is completed by all staff in all departments every year in August. Monitoring of staff completing care of residents with known difficult behaviors during care was completed by the DON starting on 6/4/25. Monitoring was done 3x/week for 4 weeks. No incidents noted during monitoring period. Completion Date 09/23/25	

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L0035	Continued from page 2 stated that resident had her hands folded up in her shirt and that she had smeared fecal matter into her shirt. NA #8 stated she did ask the resident not to play in her stool but she never made contact with her. NA #8 was immediately suspended pending investigation to ensure the safety of Resident #40 and all the other residents. The facility unsubstantiated this allegation as Resident #40 does not have any injury to her hands and after interviewing other staff members, there is no indication to prove or disprove abuse. The only two witnesses in the room have conflicting statements and the resident is unable to provide her own statement. An interview on 9/16/25 at 2:07 PM with NA #7 revealed that she observed NA #8 hit Resident #40's left hand on the top of her hand twice with an open hand. This incident occurred on 12/10/24 around 7:30 AM. She stated the 'smacks' were loud enough to hear. NA #7 stated Resident #40 was resistive to care and had raised her hand to hit NA #8 when NA #8 hit the resident. NA #8 was making nonsense sounds like 'wa wa' mimicking the sounds the resident was making. NA #7 stated that Resident #40 jerked her hand back after NA #8 hit her. NA #7 stepped between the resident and NA #8 and asked NA #8 to leave the room which she did. NA #7 finished Resident #40's incontinence care, got her dressed, and up in her wheelchair. When NA #7 left the room after care, NA #8 was waiting in the hall. She did not say anything to her about the incident and worked the rest of the day as normal. NA #7 was not sure if NA #8 worked the rest of the day or not. NA #7 stated that NA #8 was supposed to be observing care and not assisting with direct resident care during this orientation period. NA #7 stated she thought she said something to the nurse on the morning of the incident but was unable to say who the nurse was or what time she reported it. An interview on 9/16/25 at 2:04 PM was attempted for NA #8. The phone number provided was no longer in service and the facility was unable to provide another phone number. An interview on 9/17/25 at 1:20 PM with Nurse #2 revealed she remembered Resident #40 and had frequently been assigned to provide care for her, but did not remember NA #7 reporting the incident to her and was unaware of the incident on 12/12/24. An interview on 9/17/24 at 4:08 PM with the Director of Nursing (DON) revealed she completed a telephone interview with NA #8. She was unable to provide documentation for the telephone interview except as she included in her investigation summary. The DON stated	L0035		

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L0035	Continued from page 3 that NA #7 reported the incident to her on 12/12/24 at 2:00 PM which she immediately reported to the Administrator and an initial abuse allegation report was filed with the state agency. NA #8 was immediately suspended and never returned to the facility. An interview on 9/18/25 at 11:40 AM with the Administrator revealed she became aware of the abuse allegation on 12/12/24 at 2:00 PM when NA #7 informed the DON. She stated the facility completed an investigation and did not substantiate it as the staff gave conflicting statements. She stated that NA #8 was suspended as soon as the DON became aware of the abuse allegation.	L0035		