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

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

(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
F0000	INITIAL COMMENTS The survey team entered the facility on 05/21/26 to conduct a complaint investigation survey and exited on 05/22/26. Additional information was obtained on 05/26/26 and 05/27/28. The survey team returned to the facility on 05/28/26 to obtain additional information and exited on 05/28/26. Therefore, the exit date was changed to 05/28/26. Event ID# 232D52-H1. The following intakes were investigated: 2969923, 3012980, and 3013051. 2 of the 5 complaint allegations resulted in deficiency. Past Non-Compliance was identified at: CFR 483.25 at tag F684 at a scope and severity (G). Non-compliance began on 04/27/26. The facility came back in compliance effective 05/01/26.	F0000		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: 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	F0684	"Past Noncompliance - no plan of correction required"	06/12/2026

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 reverse for further 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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F0684 SS = G	Continued from page 1 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 5/4/26 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 04/16/21. 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 3/10/26, revealed that Resident #1 was 1) moderately cognitively impaired, 2) had other behavioral symptoms not directed towards others	F0684		06/12/2026

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F0684 SS = G	Continued from page 2 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 to impaired mobility and impaired cognition, and c) non-ambulatory and staff were to check on the resident frequently when performing care rounds; 3) behavior problems and noted that she would a) remove her clothing and place herself on the floor, b) often yelled and screamed at staff and others; 4) at risk for falls related to confusion, gait and balance problems, and poor safety awareness secondary to dementia, history of cerebral infarction, and history of falls and interventions included to follow the facility's fall protocol; 5) chronic pain and restless leg syndrome related to bilateral lower extremity pain and interventions included a) anticipate need for pain relief, b) respond immediately to any complaint of pain, c) administer analgesia as per physician orders, and d) evaluate the effectiveness of pain interventions. Record review of Resident #1's progress notes revealed there was no documentation of the resident on 4/27/26 written by Nurse #1 in the medical record. A telephone interview was conducted with Nurse #1 on 5/26/26 at 1:36 PM. Nurse #1 confirmed she worked on 4/26/26 from 7:00 PM to 7:00 AM on 4/27/26 and had been assigned to care for Resident #1. Nurse #1 explained Resident #1 had a lot of behaviors which included yelling out often, kicking her bedside table, and kicking at staff who come near her. She stated Resident #1 would also throw objects at staff. At one point in the night, Nurse #1 heard Resident #1 screaming out and she went to her room to check on her. Nurse #1 did not recall	F0684		06/12/2026

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F0684 SS = G	Continued from page 3 the time of this assessment. Nurse #1 stated another time she observed the resident in bed was when she heard Resident #1's tube feeding pump beeping and she went to the room to check on it. She stated she did not know the exact time of that visit to her room but explained she had been doing her medication pass at that time and thought it might have been around 4:30 AM. Nurse #1 stated Resident #1 was not yelling out at this time and when she got to the resident's room, she observed the resident lying on her back on the floor mat to the right of the resident's bed. Nurse #1 stated she stood in the doorway and yelled for nursing assistant (NA) #1. Nurse #1 explained that while she waited on NA #1 to get to the room, she turned her focus back to Resident #1 and noticed the resident had managed to wedge herself under her overbed table (below the tabletop and above the legs of the table on the floor). Nurse 1 stated Resident #1 started screaming, "help me, help me." She asked the resident if she was in pain and said the resident just stared at her. As she continued to wait for NA #1, she took the resident's vital signs using a small blood pressure cuff that she kept in her pocket and stated that the resident's vital signs had been normal. She then assessed the resident and said she had no apparent injuries at that time. Nurse #1 stated when NA #1 got to the room, they lowered the resident's bed as low to the floor as it would go, approximately 12" from the floor. She admitted that she knew Resident #1 required a total mechanical lift but said the lift was not on the floor at that time, so when NA #1 got to the room, she said she instructed NA #1 to put her hands under the resident's shoulders while she stood between the resident's legs and placed her hands on the resident's buttocks and used her forearms to support the back of the resident's thighs. They lifted Resident #1 and placed her back in her bed. After they checked to see if the resident required incontinence care and found that she did not, Nurse #1 stated she resumed her medication pass on the 300 hall. She stated she had been very tired that night because she had been pulling a lot of shifts lately and that she forgot to do the incident report. She said she was tied to the medication cart for the rest of her shift. Nurse #1 explained after she completed her 300 hall medication pass, she then completed her medication pass on her half of the 100 hall and then she and another nurse went over to the Assisted Living Unit and completed their assigned medication passes on that unit. Nurse #1 stated by the time she returned to the 300 hall, the dayshift staff had begun to come in. She then counted the 100 hall cart with the medication aide and then counted the 300 hall cart and did report with Nurse #2. Nurse #1 stated by then, the incident	F0684		06/12/2026

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F0684 SS = G	Continued from page 4 of Resident #1 being found on the floor had slipped her mind and therefore she did not report it to Nurse #2. Nurse #1 confirmed that she also did not complete an incident report about it nor make notifications to the medical provider and Resident #1's Responsible Party. Nurse #1 stated after she and NA #1 had left Resident #1's room, she had no further conversations with her. She denied having told NA #1 not to tell anyone about the resident's fall and said she had heard that NA #1 told administration that, but it was not true. Nurse #1 thought that NA #1 said that to save her job because she got fired and NA #1 still had her job. She said she had to meet with the Administrator, Director of Nursing and another lady who she did not know. She said they asked her if she knew what processes she had to follow when a resident fell, she told them she did, and said she told them what those processes were. She added that if you are not in the middle of a medication pass that was what you were supposed to do but said she was in the middle of a medication pass. Nurse #1 stated she did not believe that the resident was hurt, that the resident never indicated she was in pain and said that to the best of her recollection, Resident #1 never screamed out again the rest of the night. A telephone interview was conducted with NA #1 on 5/22/26 at 8:53 AM. 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,	F0684		06/12/2026

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F0684 SS = G	Continued from page 5 "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 needs at times, but at	F0684		06/12/2026

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F0684 SS = G	Continued from page 6 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	F0684		06/12/2026

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F0684 SS = G	Continued from page 7 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 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	F0684		06/12/2026

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F0684 SS = G	Continued from page 8 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	F0684		06/12/2026

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F0684 SS = G	Continued from page 9 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 came, the nurse said EMS personnel began an intravenous line (IV), administered ketamine (a fast-acting anesthetic used for sedation and pain relief), splinted the resident's leg and then took her to the hospital. Nurse #3 indicated at 6:01 AM, she received a call from a doctor in the Emergency Department (ED), who informed her that Resident #1 had a massive tibia fibula fracture. After that call, Nurse #3 said she called the Director of Nurse (DON) to inform her. She stated the DON told her to call the Administrator which she did. Nurse #3 stated that after the g-tube issue had resolved, Resident #1 had settled down and never yelled out like she was known to do, until she heard her scream.	F0684		06/12/2026

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F0684 SS = G	Continued from page 10 A review of Resident's Medication Administration Record (MAR) for 4/28/26 revealed Nurse #3 administered a dose of acetaminophen on 4/28/26 at 3:20 AM. Record review revealed a progress note written by Nurse #3 on 4/28/26 at 4:20 AM. It read, "…At approximately [12:30 AM] … Resident denied pain. At approximately [3:15 AM] resident hollered out complained of left leg pain; PRN [as needed] Tylenol administered… Tylenol tolerated." Another progress note written by Nurse #3 on 4/28/26 at 5:30 AM read, "Assume shift change report from [name of Nurse #2]; stated resident had new area to left lower leg; red in color, warm to touch. Order was received for venous doppler study to be done… Resident lying in bed; alert; continues to deny pain… At approximately [3:20 AM]; resident hollered out several times; [Name of NA #4] checked on resident; stated resident said hurting. Prepared PRN Tylenol for pain; upon entering residents' room; resident was holding left leg; noted the discoloration to the mentioned area was now extending upward toward her left knee and her left foot was bluish in color and cool to touch; resident move her leg when touched by this writer; I observed the flaccidity of the lower leg at this time; leg was immobilized with myself and [name of Nurse #4], PRN pain medication administered via G-tube… Hospice was notified of findings of leg at [3:36 AM]… Order to send resident to ER [emergency room] for further evaluation. At 0400; 911 was initiated… leg assessed by EMS personnel; leg was immobilized by EMS personnel IV started… resident received pain medication via IV site by EMS personnel… At [6:00 AM], [name of hospital] confirm tib/fib [tibia and fibula] fracture of residents left lower leg. [6:03 AM] DON was notified of call and confirmation from hospital. At [6:07 AM] Executive Director [Administrator] was notified. A telephone interview was conducted with Nurse #4 on 5/22/26 at 8:16 AM. Nurse #4 confirmed she worked on 4/27/26 from 7:00 PM to 7:00 AM on 4/28/26. Nurse #4 stated she was not assigned to care for Resident #1. Nurse #4 explained that around 9:00 PM, she had gone outside to take a break and NA #1 was telling her the story of how Resident #1 had thrown herself on her bedside table and said NA #1 did not say anything else. Nurse #4 said she went back inside to continue with her medication pass and said at that point, what NA #1 had said was just a story, that she had said nothing about a fall, and that she did not think twice about it after 11:00 PM when NA #1 left. Later, Nurse #4 said that Nurse #3	F0684		06/12/2026

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F0684 SS = G	Continued from page 11 asked her to look at Resident #1's g-tube (gastrostomy tube) and what was coming out of it and that they had talked about calling hospice about it. Nurse #4 said that while she was in the resident's room, she observed a bruise on her left leg and that was when she put two-and-two together and thought about the story that NA #1 had told about the resident. Nurse #4 said that when Nurse #3 went into the room to look at Resident #1's leg, the bruising and swelling looked worse and that the resident's left foot was blue down to her toes. Nurse #4 said that at that point, her leg looked broken and commented that 4 hours earlier, it had not looked like that. Nurse #4 explained that when Nurse #3 held Resident #1's leg up to get a better look at it, her bone in the leg looked like it was rubbery in that area and it looked floppy. Nurse #4 said Resident #1 had not yelled out through the night like she was in pain, but when Nurse #3 held her leg like that, the resident cried out in pain. She said when she first saw the bruise, she asked Nurse #3 if there was anything in the chart about it and they looked and saw that the resident had been given Tylenol around 7:00 AM that morning. Nurse #4 stated at that point, she felt like the Director of Nursing (DON) should have been called but Nurse #3 did not call her, although she does think that Nurse #3 called the hospice nurse. Nurse #4 stated the facility terminated her employment because she failed to report abuse in a timely matter. She stated she did not know anything about any abuse. She stated that when they were sending Resident #1 out to the hospital, Nurse #3 called the 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	F0684		06/12/2026

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F0684 SS = G	Continued from page 12 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 5/4/26, 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	F0684		06/12/2026

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F0684 SS = G	Continued from page 13 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 got home and that was why she did not want to take the time to do an incident report or make notification calls to anyone. The DON stated it was her expectation that the nurses provide the care and do the job of a nurse – to come in, take care of the resident, give them their medications, keep them safe, and answer any questions. The DON also stated she expected the nurses to follow facility policy for residents' falls which gives them clear instruction what to do after a fall – assess resident, start neurological checks for any unwitnessed falls, contact the medical provider and family, and complete a falls report under risk management. An interview was conducted with the Administrator of 5/22/26 at 2:19 PM. The Administrator explained that she had received a call from Nurse #3 on 4/28/26 when she was on her way to work that morning. She further explained that Nurse #3 informed her that she had sent Resident #1 out to the hospital due to a lot of discoloration in her left lower leg. Nurse #3 explained she had also informed the DON of this. The Administrator stated that as soon as she got to work, she began an investigation of what had occurred to Resident #1 to cause this leg injury. She stated Nurse #3 had suggested we talk with Nurse #1 and NA #1 for more information regarding the situation. The Administrator stated she had their Corporate Nurse Consultant call NA #1 who eventually told what had happened to Resident #1. The Administrator explained interviews with Nurse #1 eventually "came around" and explained what had happened to Resident #1. The Administrator stated it was her expectation that when a resident falls, nursing staff follow facility's fall policy which included making notifications by contacting the medical provider and the residents' Responsible Party. A review of the facility's Initial Allegation Report, completed by the Administrator on 4/28/26, indicated they became aware of Resident #1's	F0684		06/12/2026

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F0684 SS = G	Continued from page 14 fractures to her left tibia and fibula when she had been sent to the hospital for evaluation of discoloration and discomfort of her left leg on 4/28/26. Notifications were made to the North Carolina Division of Health Service Regulation, to Robeson County Adult Protective Services, and to local law enforcement on 4/28/26. The Administrator then began an investigation of Resident #1's injuries. The facility's Investigation Report was reviewed. The Administrator wrote the following summary, dated 5/4/26: "After a thorough investigation, including interviews with staff and residents, it was noted that the resident had a fall on 04/27/2026 at approximately 5:00 AM, which resulted in a fracture of the left tibia and fibula. The nurse who was on duty while the fall occurred did not complete the proper procedures and therefore was suspended immediately. The resident's nurse aide was also suspended pending further investigation. Further, it was determined that another nurse did not follow the proper procedure when a fall occurred, and she was also suspended. The cause of the injury was determined to be the fall that occurred from the resident's bed. The investigation for an injury of unknown origin is unsubstantiated. However, the investigation revealed that the nurse who observed the resident on the floor did not assess the resident or complete the proper fall assessment procedures. Therefore, the facility is substantiating this as neglect. This will be reported to the board of nursing." A telephone interview was conducted with the Medical Director on 5/22/26 at 1:37 PM. The Medical Director stated that she was not made aware of Resident #1's fall at the time of the fall and stressed the importance of informing a medical provider after a resident falls. She said had appropriate notifications been made, the hospice provider would have been called, and they would have guided the resident's care and treatment sooner. She also explained that she had been a hospice doctor for 7 years and the type of fracture Resident #1 sustained after her fall was not unusual for residents like Resident #1, a bedbound resident with chronic immobility, and that those types of fractures could happen with minor trauma and even with no trauma at all. She further explained that prolonged immobility causes disuse osteoporosis and the tibia is very vulnerable to bone mass loss, stating that the tibia could have up to 70% bone loss. The Medical Director stated that a spontaneous fracture of the long bone affects 1% of nursing home residents per year and that Resident #1 was the	F0684		06/12/2026

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F0684 SS = G	Continued from page 15 perfect candidate for these types of fractures. When asked if the nurse could have caused the fractures when they picked the resident up off the floor, she said that she would not think that would have caused the fractures, but that action could have caused the fractures to be more displaced. The Medical Director stated it was her expectation nurses notify a medical provider after resident falls. A telephone interview was conducted with Resident #1's Responsible Party (RP) on 5/26/26 at 11:58 AM. The RP stated he was not informed about Resident #1's fall on 4/27/26 after it happened. He explained that he had received a call on 4/27/26 when they had suspected a blood clot and that the doppler study was ordered. He said he received a call around 5:00 AM the following morning telling him that Resident #1 had a fracture, and he went to the hospital and observed her leg to be very obviously broken. The RP stated that Resident #1 had to go back to the hospital after one of the bones that was fractured splintered through her skin and she had developed an infection which required her to be admitted to the hospital a second time so she could receive intravenous (IV) antibiotics. The RP said he talked at length with the doctors that first admission and they explained to him that Resident #1 was not a candidate for surgery secondary to her brittle bones and that she was not a candidate for general anesthesia. The RP said he has been very pleased with the care the resident gets at the facility and that he has no concerns about the way they handled this situation with Nurse #1 not doing what she was supposed to do after Resident #1's fall. He said he feels the facility is taking good care of her since the fall and doing well managing her pain. The Administrator submitted the following Corrective Action Plan: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 04/27/2026, Resident #1 was observed on the floor at approximately 5:30 a.m. The fall was not immediately reported to the provider or responsible party, and required documentation (incident report, fall risk assessment, and post-fall evaluation in the electronic medical record) was not completed at the time of the incident. On 04/27/2026, Resident #1 was assessed by Nurse #2 at 3:35 p.m. after report of pain, discoloration, and warmth to her left lower extremity, with the assessment reflecting discoloration and warmth to touch. The resident's nurse practitioner was notified	F0684		06/12/2026

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F0684 SS = G	Continued from page 16 at 3:45 p.m. on 04/27/2026, and a venous doppler of resident #1 left lower extremity was ordered to evaluate for blood flow and to detect blockage in the vein. The resident #1's responsible party was notified at 4:45 p.m. on 04/27/2026. At approximately 3:20 a.m. on 04/28/2026, further assessment from Nurse #3 revealed that discoloration to the previously mentioned area was extending upward toward her left knee, and her left foot was bluish in color, cool to the touch, and flaccid. Resident #1's nurse practitioner was notified of findings by Nurse #3 at approximately 3:36 a.m. At 4:00 a.m., Nurse #3 received orders from Resident #1's nurse practitioner to send Resident #1 to the Emergency Department for evaluation, where Resident #1 was found to have displaced and angulated fractures of the left tibia and fibula and extra-articular distal tibia and fibula diaphyseal fractures with mild angulation of the left tibia and fibula (fractures of the left tibia and fibula, including fractures in the lower portion of the leg bones, with mild displacement and angulation). Resident #1's responsible party was also notified at approximately the same time. Resident #1 returned to the facility on 05/04/2026. Appropriate interventions were implemented; the North Carolina Department of Health and Human Services, local police department, and adult protective services were contacted on 04/28/2026. Staff involved received supervisory intervention for failure to follow reporting and documentation requirements. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Any resident has the potential to be affected. The following audit was conducted to evaluate residents who had the potential to be affected: On 04/28/2026, the minimum data set nurse and admissions nurse conducted head-to-toe assessments on all residents to identify any undetected injuries or changes in condition. Assessments were completed on 04/29/2026 with no issues identified that hadn't already been addressed. On 04/28/2026, the director of nursing and social worker interviewed alert and oriented residents regarding facility safety and care. This was completed on 04/29/2026. No issues identified that hadn't already been addressed. On 4/28/2026, the director of nursing, staff	F0684		06/12/2026

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F0684 SS = G	Continued from page 17 development coordinator, assisted living coordinator, admissions nurse, and minimum data set nurse interviewed all staff to ask if they were aware of any potential fall or incident that may have occurred but was not reported. This was completed on 04/30/2026. No issues identified that hadn't already been addressed. On 04/30/2026, the director of nursing reviewed the facility's fall log from 02/01/2026 to 04/30/2026 to identify residents who experienced falls. On 04/30/2026, the director of nursing audited the medical records of residents who experienced falls to verify that proper fall assessment procedures were completed, physicians were notified, and care plans were updated as appropriate. Any residents identified as having incomplete fall assessments or care plan updates had those deficiencies corrected by 04/30/2026. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 04/28/2026, the director of nursing conducted an in-service for licensed nurses on proper fall assessment procedures, including immediate assessment of the resident, completion of the fall assessment tool, physician notification, and care plan review and revision as indicated. Licensed nurses who did not receive education on this date received it prior to their next working shift. On 04/28/2026, the director of nursing conducted an in-service for nurse aides and medication aides on their role in fall prevention and the importance of immediate notification to licensed nursing staff when a fall occurs. Nurse aides and medication aides who did not receive education on this date received it prior to their next working shift. On 4/28/2026, the administrator and director of nursing conducted in-servicing for all staff on Lutheran Services Carolinas policy on abuse, neglect and required reporting. All in servicing not completed by 04/28/2026 was completed prior to each staff members next working shift. On 04/30/2026, the administrator added a quiz regarding neglect to new hire orientation materials to ensure that newly hired staff understand their responsibility to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress.	F0684		06/12/2026

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F0684 SS = G	Continued from page 18 On 04/30/2026, the administrator posted neglect awareness flyers with pull tabs containing reporting information throughout the facility in common areas including staff break rooms, nursing stations, and resident common areas. On 04/30/2026 the facility's fall assessment procedure was reviewed and revised to include a checklist requiring licensed nurse signature confirming completion of resident assessment, fall assessment tool completion, physician notification, and care plan review. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Beginning 04/30/2026, the director of nursing began reviewing all falls and incidents during the clinical meeting with the Interdisciplinary team in the morning meetings to ensure all documentation and notification was complete, including proper assessments and care plan revisions. Any incomplete documentation will be corrected, and the director of nursing will ensure correction occurs. This will continue as an ongoing new process for the facility. The administrator or social worker will conduct weekly interviews with a random sample of 5 residents to identify any concerns regarding neglect or failure to provide necessary goods and services. This will continue for four weeks and then monthly for three months. The administrator or social worker will conduct weekly interviews with a random sample of 5 staff to identify any concerns regarding neglect or failure to provide necessary goods and services. This will continue for four weeks and then monthly for three months. The staff development coordinator or director of nursing will audit five staff interactions with residents per week for four weeks and then 10 residents per month for three months to ensure there are no concerns with abuse, neglect, or other during resident/staff interactions. The director of nursing or minimum data set nurse will audit the electronic medical record for appropriate notification to the provider and responsible party regarding incidents at the following frequency: 5 incidents per week for four	F0684		06/12/2026

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F0684 SS = G	Continued from page 19 weeks then 10 incidents per month for three months. The director of nursing or administrator will interview staff to assess their ongoing understanding of the fall management policy, including reporting and documenting incidents. Teammates were asked if they had observed any residents on the floor, whether incidents were reported, and if they knew of any unreported falls. Interviews also evaluate staff knowledge of fall procedures, including completing a risk assessment that prompts further management investigation. The director of nursing will complete 5 interviews per week for four weeks and then 10 interviews per month for three months. The director of nursing will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee on May 14, 2026. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis quarterly until substantial compliance of the set-forth protocol is achieved. Changes will be made immediately, if needed. The alleged date of compliance for the corrective action plan: 5/01/26. Validation of the facility's Corrective Action Plan was completed on 5/28/26. The validation included the following: Reviewed the head-to-toe assessments completed on all residents. Reviewed the interviews that were completed on alert and oriented residents. Reviewed the staff interviews which were conducted to find out if they were aware of any falls that may have occurred but were not reported. Reviewed the facility's audits on falls from 2/21/26 through 4/30/26. Reviewed the in-service education and staff roster of those who attended that was provided to licensed nurses on proper fall assessment procedures. Reviewed the in-service education and the signature roster of those who attended that was provided to nursing assistants and medication aides on their role in fall prevention and the importance of immediate notification to licensed staff when a fall occurs. Reviewed the in-service education, and the	F0684		06/12/2026

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

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

(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
F0684 SS = G	Continued from page 20 signature roster of those who attended, that was provided on Lutheran Service Carolinas policy on abuse, neglect, and required reporting. Reviewed the quiz created by the Administrator that was added to the new hire orientation materials regarding neglect. Reviewed the neglect awareness flyers the Administrator created and posted in common areas. Reviewed the revised fall assessment procedure that requires nursing confirming completion of the resident assessment, fall assessment tool completion, physician notification, and care plan review. Reviewed audits completed by 5/22/26 regarding interviews with a random sample of 5 residents to identify any concerns regarding neglect or failure to provide necessary goods and services. Reviewed audits completed by 5/22/26 of staff interviews to identify any concerns regarding neglect or failure to provide necessary goods and services. Reviewed audits completed by 5/22/26 of staff interactions with residents Reviewed audits completed by 5/22/26 of electronic medical record for appropriate notification to the provider and responsible party regarding incidents. Reviewed audits completed by 5/22/26 of staff interviews regarding their understanding of the falls management policy, including reporting and documenting incidents. Interviewed staff who were able to verbalize the education that was provided to them. Reviewed the topics discussed during, and signature roster of those who attended, the facility's Quality Assurance and Performance Improvement (QAPI) meeting held on 5/14/26. Topics included discussion of the facility's Plan of Correction for Resident #1's fall incident that occurred on 4/28/26. The compliance date of 5/01/26 for the Corrective Action Plan was validated.	F0684		06/12/2026