

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2026
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 149 HIGHWAY 87 REIDSVILLE, NC 27320
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation from 01/13/26-01/15/26 with a telephone exit on 01/15/26. The complaint investigation was initiated by the Rockingham County Department of Social Services on 01/05/26.	C 000		
C 015	10A NCAC 13G .0214 Suspension of Admissions 10A NCAC 13G .0214 Suspension of Admissions (a) Either the Secretary or his designee shall notify the domiciliary home by certified mail of the decision to suspend admissions. Such notice will include: (1) the period of the suspension, (2) factual allegations, (3) citation of statutes and rules alleged to be violated, (4) notice of the facility's right to contested case hearing or the suspension. (b) The suspension will be effective when the notice is served or on the date specified in the notice of suspension, whichever is later. The suspension will remain effective for the period specified in the notice or until the facility demonstrates to the Secretary or his designee that conditions are no longer detrimental to the health and safety of the residents. (c) The home shall not admit new residents during the effective date of the suspension. (d) Any action taken by the Division of Facility Services to revoke a home's license or to reduce the license to a provisional license shall be accompanied by a recommendation to the Secretary or his designee to suspend new admissions. A suspension may be ordered without the license being affected.	C 015		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2026
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 149 HIGHWAY 87 REIDSVILLE, NC 27320
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 015	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to adhere to rules and regulations related to admitting five residents (#1, #2, #3, #4, and #5) during a Suspension of Admissions (SOA).</p> <p>The findings are:</p> <p>Review of the facility's current license effective 01/01/26 through 12/31/26 revealed the facility was licensed for 6 ambulatory residents.</p> <p>Review of a letter from the Division of Health Service Regulation (DHSR), Adult Care Licensure Section dated 09/26/24 revealed: -An annual survey was conducted by the Adult Care Licensure Section at the facility on 09/25/24, at which time a violation was identified in 10A NCAC 13G .0302 Design and Construction and a plan of protection was requested -The Construction Section completed a biennial survey on 09/17/24, at which time a violation was identified in 10A NCAC 13G .0302 Design and Construction. -The conditions of the home were found to be detrimental to the health, safety, and welfare of the residents. -Admissions to the home were to be suspended immediately.</p> <p>Review of a letter from the DHSR, Adult Care Licensure Section dated 11/22/24 revealed: -The facility's 2025 license renewal was approved. -The suspension of admission issued on 09/26/24 remained in force until conditions or circumstances merited removing the suspension.</p>	C 015		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2026
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 149 HIGHWAY 87 REIDSVILLE, NC 27320
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 015	<p>Continued From page 2</p> <p>Interview with five residents on 01/05/26 from 3:17pm-3:28pm revealed: -They arrived at the current facility on 01/04/26. -A resident was told by staff at the previous facility on 01/02/26 that she would be moving to the current facility. -Another resident was told by staff a couple of weeks before residents moved to the facility. -A third resident knew for a week before residents moved that she would have to leave the previous facility. -A fourth resident had not been told about moving to the current facility, but she heard other residents talking about moving to the current facility. -This facility where they currently resided was temporary. -They were unaware of how long they would be at this facility.</p> <p>Observation of the facility on 01/13/26 at 7:38am revealed five female residents exited the front door of the facility and sat down on the front porch.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 01/13/26 at 7:42am revealed: -There were 5 residents residing in the facility. -She could not say why the residents moved to this facility from another facility; only the Administrator could answer that question.</p> <p>Interview with one of the residents on 01/13/26 at 7:38am revealed the residents all left the facility for a day program from around 8:00am-2:30pm.</p> <p>Interview with a Co-Administrator on 01/13/26 at 7:57am revealed: -The residents were moved to this facility</p>	C 015		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2026
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 149 HIGHWAY 87 REIDSVILLE, NC 27320
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 015	<p>Continued From page 3</p> <p>because of a septic tank issue with the sister facility.</p> <ul style="list-style-type: none"> -She did not know any other details; the Administrator made the decision. -This facility was leased out to another individual, and when the annual survey was completed, one of the residents did not leave the facility during a fire drill, and the person who leased the facility decided to "get out of the business". -The SOA was against the person who leased the facility at the time of the annual survey. -Both the Department of Social Services (DSS) for the county where the residents were moved from and the DSS the residents moved to were notified. -It was an emergency move because even though the pump and haul (a system where waste collected in a tank and periodically pumped when the telemetry system sent an alert) company was pumping the septic tank, it was still backing up into the shower. -The residents' guardians were notified of the move on 01/04/25. <p>Telephone interview with the Administrator on 01/13/26 at 8:57am revealed:</p> <ul style="list-style-type: none"> -The residents were moved because the current septic system at the sister facility was costing him over \$1000.00 per month. -The pump and haul company was pumping the septic tank several times per month. -He had contacted a [named] septic company who said the repairs to the septic system would take a week to complete. -The current tank was too low, and the water was going into the drain field. -The septic company was going to add on to the drain field, get the elevation right, and the facility may need a new tank. -The septic company notified him on 01/02/26 	C 015		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2026
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 149 HIGHWAY 87 REIDSVILLE, NC 27320
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 015	<p>Continued From page 4</p> <p>that they would begin work on 01/05/26.</p> <ul style="list-style-type: none"> -He moved the residents from the sister facility to a safe environment while the work was being done on the septic tank. -He knew this facility was ready to have residents move in, so when he thought the septic system work was going to begin on 01/05/26, he moved the residents in on 01/04/26. -Someone at the [named] septic company was sick, and the work did not start on 01/05/26 as planned, and he did not know when the work would begin. -He notified the residents' guardians that the work was going to happen, but he did not know when. -He sent a letter to each resident's guardian on 01/05/26. -He knew the facility had a suspension of admission in place. -He did not have anywhere else to move the residents. -He did not want to lose his residents to somewhere else. -The SOA from 2024 was due to a resident not exiting during a fire drill. -He had reached out to the county DSS, and a [named] individual with DHSR about the SOA, but no one knew what to do. <p>1. Review of Resident #1's current FL2 dated 10/27/25 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included schizophrenia, diabetes, depression, and anxiety. -She was intermittently disoriented, ambulatory, had occasional incontinence, had wandering behavior, and required staff assistance with bathing and dressing. <p>Review of Resident #1's Resident Register revealed an admission date of 01/04/26.</p>	C 015		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2026
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 149 HIGHWAY 87 REIDSVILLE, NC 27320
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 015	<p>Continued From page 5</p> <p>Interview with Resident #1 on 01/13/26 at 7:43am revealed: - She moved into the facility 1 week and 1 day ago. -They moved because there was something wrong with the septic system. -She did not know how long they would stay at the new facility. -Her family was notified that she moved to the new facility.</p> <p>Telephone interview with Resident #1's guardian on 01/13/26 at 10:04am revealed: -He was notified by telephone on 01/06/26 that the sister facility had a problem with the septic system and the residents would be temporarily moved to this facility. -The Administrator did not know how long the residents would be at this facility, and the septic company was supposed to be at the sister facility on 01/05/26 but cancelled.</p> <p>2. Review of Resident #2's current FL2 dated 10/27/25 revealed: -Diagnoses included mild intellectual disability, depression, and hyponatremia. -She was ambulatory. -She required no staff assistance with bathing, feeding, or dressing.</p> <p>Review of Resident #2's Resident Register revealed an admission date of 01/04/26.</p> <p>Interview with Resident #2 on 01/13/26 at 7:45am revealed: -She moved into the facility 1 week ago. -She was not sure why she moved into the new facility but thought maybe it was because of construction. -She was not sure if her guardian was notified of</p>	C 015		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2026
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 149 HIGHWAY 87 REIDSVILLE, NC 27320
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 015	<p>Continued From page 6</p> <p>the move into the new facility.</p> <p>Attempted telephone interview with Resident #2's guardian on 01/13/26 at 9:47am was unsuccessful.</p> <p>3. Review of Resident #3's current FL2 dated 12/01/25 revealed diagnoses included type 2 diabetes and catatonic schizophrenia.</p> <p>Review of Resident #3's Resident Register revealed she was admitted to the facility on 01/04/26.</p> <p>Interview with Resident #3 on 01/13/26 at 7:42am revealed:</p> <ul style="list-style-type: none"> -The residents were moved to this facility because of the septic tank at the other facility. -She was told about a month ago that the move was going to happen, but they did not know when it was going to happen. -The alarm to the septic system was constantly "going off," but the commodes were not backing up. -The residents moved to this facility about a week ago. -She did not know if her family/guardian was notified. <p>Telephone interview with Resident #3's guardian on 01/13/26 at 10:04am revealed:</p> <ul style="list-style-type: none"> -He was notified by telephone on 01/06/26 that the sister facility had a problem with the septic system and the residents would be temporarily moved to this facility. -The Administrator did not know how long the residents would be at this facility, and the septic company was supposed to be at the sister facility on 01/05/26 but cancelled. 	C 015		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2026
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 149 HIGHWAY 87 REIDSVILLE, NC 27320
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 015	<p>Continued From page 7</p> <p>4. Review of Resident #4's current FL2 dated 10/27/25 revealed: -Diagnoses included schizoaffective disorder bipolar type, narcissistic personality disorder, and chronic obstructive pulmonary disease. -She was intermittently disoriented.</p> <p>Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility on 01/04/26.</p> <p>Interview with Resident #4 on 01/13/26 at 7:48am revealed: -The residents were moved to this facility because the septic system at the other facility needed to be pumped. -The septic system was not backing up. -She wanted to move back to the other facility as soon as the septic system was fixed. -She did not know if her family/guardian was notified.</p> <p>Attempted telephone interview with Resident #2's guardian on 01/13/26 at 9:45am was unsuccessful</p> <p>5. Review of Resident #5's current FL2 dated 10/27/25 revealed diagnoses included schizophrenia disorder bipolar type, dependent personality disorder, and diabetes type 2.</p> <p>Review of Resident #5's Resident Register revealed she was admitted to the facility on 01/04/26.</p> <p>Interview with Resident #5 on 01/13/26 at 7:47am revealed: -She was admitted to the facility about a week ago. -She believed that she had to move because the</p>	C 015		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2026
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 149 HIGHWAY 87 REIDSVILLE, NC 27320
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 015	<p>Continued From page 8</p> <p>previous facility had some work to do. -She was not sure if her family member was contacted regarding the move to the new facility.</p> <p>Attempted telephone interview with Resident #2's guardian on 01/13/26 at 9:46am was unsuccessful</p> <p>_____</p> <p>The facility failed to ensure residents were moved into a facility that did not have a Suspension of Admissions (SOA) in place. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/13/26 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 1, 2026.</p>	C 015		