STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on November 16, 2021 through November 17, 2021.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure the health care needs of 2 of 5 sampled residents (#3, #6) were met related to include a resident who had irregular breathing (#6) and scheduling a urology appointment (#3). The findings are: 1. Review of Resident #6's current FL-2 dated 11/02/21 revealed: -Diagnoses included congestive heart failure, anemia, hyperlipidemia, hypertension, and depression. -The resident was semi-ambulatory with a rolling walker. -There was documentation of non-applicable under the sections titled disoriented and wanderer. Review of Resident #6's Resident Register dated 11/04/21 revealed: -The resident was admitted to the facility on 11/08/21.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

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D 273	Continued From page 1	D 273		

-The resident's memory was adequate and he ambulated with a walker/rollator.

Review of Resident #6's progress notes dated 11/11/21 revealed:
-The time was not documented.
-The resident had a change in condition.
-Vital signs were not documented.
-The resident's power of attorney (POA) was contacted and agreed to have the resident transferred to the hospital.
-The resident was sleeping and deep breathing.

Review of Resident #6's local hospital discharge summary dated 11/12/21 revealed:
-The resident arrived to the emergency department (ED) unresponsive from the facility.
-The time of arrival was not documented.
-Diagnoses included acute kidney injury on chronic kidney disease, hyperkalemia, hypothermia, and dehydration.
-His temperature was 94.1 degrees rectally (normal adult body temperature is 97 degrees - 99 degrees).
-The resident was discharged to the hospice house on 11/12/21.

Interview with the Resident Care Director (RCD) on 11/16/21 at 3:56pm revealed:
-From admission on 11/08/21 through 11/11/21, Resident #6 was confused at times and independent with ambulation.
-From admission on 11/08/21 through 11/11/21, Resident #6 required staff assistance with dressing and bathing.
-From admission on 11/08/21 through 11/11/21, Resident #6 was normally alert, talkative, and smiling.
-On 11/11/21 between 7:00am and 8:00am she went to administer Resident #6 his medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

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D 273	Continued From page 2	D 273		

-Resident #6 was in bed, "lethargic", had mumbled speech, and would not follow commands.
-Resident #6 would take a breath and pause before taking another breath.
-Resident #6 could not take his medications because he was "lethargic" and not acting as he normally did.
-On 11/11/21, she did not notify Resident #6's Primary Care Provider (PCP) or call 911.
-On 11/11/21, she checked on Resident #6 the second time around 8:15am.
-On 11/11/21 around 8:15am, Resident #6 was more alert, with speech still mumbled which was not normal for him, and his mouth was dry.
-Resident #6 would take a breath and pause before taking another breath.
-She did not notify Resident #6's PCP or call 911 when she checked on the resident the second time.
-On 11/11/21 between 11:30am and 12:00pm, she asked a personal care aide (PCA) to place Resident #6 in his bedroom chair.
-On 11/11/21, she checked on Resident #6 for the third time a few minutes after 12:00pm.
-Resident #6 was sitting in his bedroom recliner.
-Resident #6 would take deep, gasping breaths.
-Resident #6's respirations were still irregular.
-Resident #6 mumbled no when she offered him lunch.
-On 11/11/21 a little after 12:00pm, she then called Resident #6's Power of Attorney (POA) to ask if he wanted the resident to be sent to the hospital for medical evaluation.
-Resident #6's POA gave her permission to send the resident to the hospital.
-She did not notify Resident #6's PCP the resident was "lethargic", had irregular breathing, and mumbled speech.
-When a resident had a change in condition, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 273	Continued From page 3	D 273		

was trained to obtain vital signs and contact the residents responsible party to ask permission to send to the hospital before notifying the PCP.
-It did not occur to her to notify Resident's PCP or call 911 when she first discovered the resident with mumbled speech and irregular respirations because she thought he had not had time to wake well.

Review of Resident #6's November 2021 electronic medication administration record (eMAR) revealed:
-There was an entry to check the resident's blood pressure once a month.
-There was no documentation Resident #'s blood pressure was checked from 11/08/21 - 11/11/21.

Telephone interview with Resident #6's POA on 11/16/21 at 6:40pm revealed:
-The resident needed staff assistance with bathing, walking, and dressing.
-The resident was confused at times.
-The resident had a history of stage 4 renal failure, dehydration, and an aortic aneurysm.
-On 11/11/21 the facility called to tell him the resident would not eat and was not responding.
-The facility wanted to send the resident to the hospital.
-The resident was transferred to a hospice house from the hospital.

Interview with the Administrator on 11/17/21 at 10:00am revealed:
-He expected the RCD to have called Resident #6's family member to ask if they wanted the resident sent to the hospital before notifying the PCP or calling 911.
-Staff were to the notify Resident #6's PCP the resident had irregular breathing, mumbled speech, and was lethargic if the resident's family

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 273	Continued From page 4	D 273		

said to not send the resident to the hospital.
-Staff had been trained by the facility to call a resident's family member before notifying the PCP if a resident had a change in condition.
-Staff knew a resident's normal behavior because they worked with the residents on a regular basis.

Attempted telephone interview with Resident #6's PCP on 11/17/21 at 4:02pm was unsuccessful.

2. Review of Resident #3's current FL-2 dated 08/30/21 revealed:
-Diagnoses included acute kidney failure and obstructive and reflux uropathy.
-The resident required a foley catheter for urination.

Review of Resident #3's hospital emergency department (ED) visit information sheet dated 07/30/21 revealed:
-The resident was treated for abdominal pain, urinary obstruction, chronic kidney disease, and a urinary tract infection (UTI).
-The resident was prescribed Keflex (an antibiotic used to treat bacterial infections) 500 milligrams (mg) three times daily for seven days.
-The resident was to follow up with a urologist.
-There was no appointment date or timeframe to follow up with urology documented.

Review of Resident #3's progress notes and physician visit notes revealed there was no documentation the resident followed up with a urologist after the 07/30/21 hospital visit.

Interview with the Administrator on 11/17/21 at 10:00am revealed:
-The Resident Care Director (RCD) was currently responsible for reviewing hospital paperwork and discharge summaries for orders and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 273	Continued From page 5	D 273		

implementing referrals.
-He did not know the process for implementing hospital orders.
-There was no process in place to ensure hospital paperwork and discharge summary orders/referrals were implemented.
-He expected referrals to be made within 24 hours or the next business day.

Interview with the RCD on 11/17/21 at 2:45pm revealed:
-The previous RCD was responsible for ensuring referrals were made.
-The RCD would fax the urology referral order to Resident #3's primary care provider's (PCP's) office.
-The PCP's office would send the urology referral to a urologist.
-The PCP would notify the RCD the urology referral was sent to the urologist.
-The RCD could call to schedule Resident #3 an appointment with the urologist.
-The RCD could wait for the urologist's office to call the facility to schedule an appointment for Resident #3.
-She did not know if Resident #3 had seen the urologist after his 07/30/21 hospital visit.

Interview with the facility's Human Resources (HR) officer on 11/17/21 at 2:57pm revealed:
-The facility did not schedule Resident #3 to see the urologist because his family member refused.
-She did not know if Resident #3's PCP was notified the urologist referral was not made.
-She did not know who was responsible for notifying the PCP when referrals were not made.

Attempted telephone interview with Resident #3's PCP on 11/17/21 at 4:02pm was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 273	Continued From page 6 The facility failed to ensure the Primary Care Provider and/or 911 was notified when Resident #6 had a change in condition which included mumbled speech and irregular breathing with pauses in between breaths which was not normal for the resident. The facility's failure resulted in a 4 hour delay in care. The resident was unresponsive and had a core temperature of 94.1 degrees Fahrenheit upon arrival to the hospital. The facility's failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. The facility provided a plan of protection on 11/17/21 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 1, 2022.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 5 residents (#4, #8, #9) observed during the medication passes	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 358	Continued From page 7	D 358		

evidenced by errors with a medication to treat high blood pressure (#8, #9) and reduce blood sugar levels (#8); medications to treat seasonal allergies, high cholesterol, depression, excess fluid, to thin the blood, to decrease stomach acid, supplemental vitamins and a mineral (#9); and a fast-acting insulin to control high blood sugar (#4).

The findings are:

The medication error rate was 12% as evidenced by the observation of 3 errors out of 25 opportunities during the 7:30am, 8:00am, and 11:45am medication pass on 11/17/21.

1. Review of Resident #8's current FL-2 dated 07/12/21 revealed:
-Diagnoses included type 2 diabetes, essential hypertension, and atherosclerotic heart disease of a native coronary artery without cerebral infarction.
-There was a notation on the medication section to see attached.

Review of Resident #8's signed physician's orders dated 07/12/21 attached to the current FL-2 revealed:
-There was an order for Metoprolol Tartrate 50mg, 1 1/2 tablets twice daily with meals. (Metoprolol Tartrate is used to treat high blood pressure and heart failure and may lower the risk of death after a heart attack.)
-There was an order for Metformin HCL 500mg take 2 tablets every morning and evening with meals. (Metformin HCL is used to treat high blood sugar levels).
-There was an order to give medication in applesauce or pudding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 358	Continued From page 8 Observation of the 7:30am medication pass on 11/17/21 revealed: -The medication aide (MA) prepared and crushed Resident #8's medications which included Metformin HCL 1000mg, one tablet and Metoprolol Tartrate 50mg, 1 ½ tablets and mixed the medications in applesauce in a small medicine cup for administration at 7:21am. -The MA entered Resident #8's room and checked the resident's fingerstick blood sugar and it was 248 at 7:28am. -The MA handed Resident #8 a spoon and the small medicine cup containing the resident's crushed medications mixed in applesauce and the MA walked back and stood at the resident's room door. -The resident took approximately ½ of the crushed medications in the applesauce and disposed of the small medication cup containing the other half of the prepared crushed medications mixed in applesauce in a trash can beside his bed at 7:30am while the MA was standing at the door talking with another staff, with her back turned toward the resident. -The MA did not observe Resident #8 take the 7:30am medications. Interview with the MA on 11/17/21 at 7:32am revealed: -Resident #8 did not like for her to stand right beside him when he took his medications. -Resident #8 liked to take his crushed medication placed in applesauce from the cup himself. -She was not aware Resident #8 did not take all the prepared and crushed medications mixed in applesauce. -Resident #8 always took all his medications. Observation of the MA on 11/17/21 at 7:32am revealed the MA removed Resident #8's trash	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 358	Continued From page 9	D 358		

can bag that contained the prepared and crushed medication in applesauce and placed the bag in the trash can on the side of the medication cart.

Review of Resident #8's November 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Metoprolol Tartrate 50mg take 1 ½ tablets twice daily with meals with a scheduled administration time at 7:30am and 5:00pm.
-Metoprolol Tartrate 50mg, 1 ½ tablets was documented as administered at 7:30am and 5:00pm from 11/01/21 - 11/17/21 at 7:30am.
-There was an entry for Metformin 1000mg twice daily with meals with a scheduled administration time at 7:30am and 5:00pm.
-Metformin 100mg was documented as administered at 7:30am and 5:00pm from 11/01/21 - 11/17/21 at 7:30am.

Interview with Resident #8 on 11/17/21 at 10:24am revealed he did not know he did not take all the medication crushed and prepared in the medication cup this morning, (11/17/21) before he placed the cup in the trash can.

A second interview with the MA on 11/17/21 at 1:04pm revealed:
-Resident #8 would become upset if she stood too close to him when he took his medications.
-She usually stood at Resident #8's room door to observe him take his medication.
-She was responsible to ensure all residents took their medications by observing the resident's swallow their medications when administering medications to the residents.

Interview with the Resident Care Director (RCD) on 11/17/21 at 3:34pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 358	Continued From page 10	D 358		

-The MAs were responsible to observe all residents swallow medications in order to ensure the medications were administered.
-The MA should have observed Resident #8 while he was taking his 7:30am medications this morning, (11/17/21) and prompted the resident that some of the medications mixed in applesauce was left in the cup before the resident disposed of the medications in the trash.
-If there was medication and applesauce remaining in the cup, then Resident #8 did not receive all his medication.

Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 11/17/21 at 4:08pm revealed it was important for the MA to ensure all of the medications mixed in applesauce was administered to the resident to ensure the resident received all of the medications as ordered.

Refer to the interview with the Administrator on 11/17/21 at 5:20pm.

2. Review of Resident #9's current FL-2 dated 07/12/21 revealed:
-Diagnoses included atrial fibrillation, hypertension, hyperlipidemia, chronic diastolic heart failure, anemia, and chronic kidney disease stage 3.
-There was a notation on the medication section to see the physician order sheet.

Review of Resident #9's signed physician's orders dated 07/12/21 attached to the current FL-2 revealed:
-There was an order for Amlodipine 5mg one tablet once daily, (Amlodipine is used to treat high blood pressure).
-There was an order for Atorvastatin 10mg one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 358	Continued From page 11	D 358		

tablet once daily. (Atorvastatin is used to decrease cholesterol).
-There was an order to check blood pressure once daily.
-There was an order for Eliquis 5mg one tablet twice daily (Eliquis 5mg is used to thin the blood to decrease the risk of a stroke).
-There was an order for Lexapro 10mg one daily, (Lexapro is used to treat depression).
-There was an order for Furosemide 40mg one tablet daily. (Furosemide 40mg is used to remove excess fluid).

Review of Resident #9's subsequent medication orders dated 09/30/21 revealed:
-There was an order may crush medications.
-There was an order for Zyrtec 10mg once daily. (Zyrtec is used to treat seasonal allergies).
-There was an order for Prilosec DR 20mg open 1 capsule and sprinkle in applesauce daily with instructions do not crush. (Prilosec is used to decrease stomach acid).
-There was an order for a Multivitamin once daily. (A Multivitamin contains a combination of vitamins and minerals used as dietary supplement).
-There was an order for Vitamin C 500mg once daily. (Vitamin C is used as a vitamin supplement).
-There was an order for Vitamin D3 2000IU (50mcg) once daily, (Vitamin D3 is used as a vitamin supplement).
-There was an order for Zinc Sulfate 220mcg/50mg once daily. (Zinc is a mineral supplement).

Observation of the 8:00am medication pass on 11/17/21 revealed:
-The medication aide (MA) prepared and crushed Resident #9's medications which included a Multivitamin, Zyrtec 10mg, Amlodipine 5mg,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 358	Continued From page 12	D 358		

Atorvastatin 10mg, Vitamin D3 2000IU, Zinc Sulfate 220mg/50mg, Furosemide 40mg, Lexapro 10mg, Vitamin C 500mg, Eliquis 5mg and mixed the medications in applesauce in a small medicine cup for administration at 8:15am.
-The MA prepared Resident #9's Prilosec 20mg by opening the capsule and sprinkled the contents in the applesauce mixed with the resident's crushed medications at 8:18am.
-Resident #9 was sitting in her room in a chair when the MA entered the resident's room.
-The MA administered Resident #9's medications mixed in applesauce at 8:19am with a spoon, gave the resident water and observed the resident swallow the medications.
-There was approximately ¼ of a teaspoon (tsp) of the medications mixed in applesauce remaining in the small medication cup.
-The MA disposed of the medication cup containing approximately ¼ tsp of Resident #9's medication mixed in the applesauce.

Review of Resident #9's November 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Amlodipine 5mg once daily with a scheduled administration time at 8:00am.
-Amlodipine 5mg was documented as administered from 11/01/21 - 11/17/21 at 8:00am
-There was an entry for Atorvastatin 10mg once daily with a scheduled administration time at 8:00am.
-Atorvastatin 10mg was documented as administered from 11/01/21 - 11/17/21 at 8:00am.
-There was an entry for Zyrtec 10mg once daily with a scheduled administration time at 8:00am.
- Zyrtec 10mg was documented as administered from 11/01/21 - 11/17/21 at 8:00am.
-There was an entry for a Multivitamin once daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 358	Continued From page 13	D 358		

with a scheduled administration time at 8:00am
-The Multivitamin was documented as administered from 11/01/21 - 11/17/21 at 8:00am.
-There was an entry for Eliquis 5mg one tablet twice daily with a scheduled administration time at 8:00am and 8:00pm.
-Eliquis 5mg was documented as administered at 8:00am and 8:00pm from 11/01/21 - 11/17/21 at 8:00am.
-There was an entry for Lexapro 10mg one daily with a scheduled administration time at 8:00am.
-Lexapro 10mg was documented as administered from 11/01/21 - 11/17/21 at 8:00am.
-There was an entry for Furosemide 40mg once daily with a scheduled administration time at 8:00am.
-Furosemide 40mg was documented as administered from 11/01/21 - 11/17/21 at 8:00am.
-There was an entry for Prilosec 20mg once daily with a scheduled administration time at 8:00am.
-Prilosec 20mg was documented as administered from 11/01/21 - 11/17/21 at 8:00am.
-There was an entry for Vitamin C 500mg once daily with a scheduled administration time at 8:00am.
-Vitamin C 500mg was documented as administered from 11/01/21 - 11/17/21 at 8:00am.
-There was an entry for Vitamin D3 2000IU (50mcg) once daily with a scheduled administration time at 8:00am.
-Vitamin D3 2000IU (50mcg) was documented as administered from 11/01/21 - 11/17/21 at 8:00am.
-There was an entry for Zinc Sulfate 220mg/50mg once daily with a scheduled administration time at 8:00am.
- Zinc Sulfate 220mg/50mg was documented as administered from 11/01/21 - 11/17/21 at 8:00am.

Interview with the MA, observed 11/17/21 on the 8:00am medication pass, on 11/17/21 at 1:04pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 358	Continued From page 14	D 358		

revealed:
-She had to crush Resident #9's medications very fine or the resident would spit the medication mixed in applesauce out of her mouth.
-She did not attempt to administer the remainder of the crushed medications in applesauce remaining in the medicine cup to Resident #9 because she saw "pieces" of medications in the cup and the resident would have spit that out.
-It was important for Resident #9 to receive all her medications for her health.
-If Resident #9 did not receive all the medications mixed in the applesauce in the cup, she could not be sure the resident had taken all the medication dosage amounts as ordered.

Interview with the Resident Care Director (RCD) on 11/17/21 at 3:34pm revealed:
-The MA should have crushed all of Resident #9's medications except Prilosec into a fine powder.
-The MA should have added more applesauce to the remainder of Resident #9's medication and applesauce mixture and administered all of the medication to the resident or the MA should have dissolved the remainder in water for the resident to take.
-If there was medication and applesauce remaining in the cup, then Resident #9 did not receive all her medication.

Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 11/17/21 at 4:08pm revealed it was important for the MA to ensure all of the medication mixed in applesauce was administered to the resident to ensure the resident received all of the medications as ordered.

Refer to the interview with the Administrator on 11/17/21 at 5:20pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

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D 358	Continued From page 15 3. Review of Resident #4's current FL-2 dated 07/12/21 revealed: -Diagnoses included type 2 diabetes with hyperglycemia without complications. -There was a notation on the medication section to see the attached orders. Review of Resident #4's signed physician's orders dated 07/08/21 attached to the current FL-2 revealed: -There was an order to check blood sugar four times a day before meals and at bedtime. If blood sugar was less than 70, give 6 ounces of orange juice and recheck in 15 minutes and contact the primary care provider (PCP) if the blood sugar was greater than 450. A sliding scale was based on the blood sugar readings as follows: 0 - 70, give 0 units; 70 - 450, give 0 units with no action; and greater than 450, give 0 units and call PCP, document on medication administration record (MAR). -There was an order for Novolog FlexPen sliding scale before meals as follows: 0 - 201 give 0 units, 201 -250 give 4 units, 251 - 300 give 6 units, 301-350 give 8 units, 351 - 400 give 10 units and greater than 400, give 10 units and call the primary care provider (PCP). (A Novolog FlexPen is a disposable prefilled device containing insulin). Observation of the 11:45am medication pass on 11/17/21 revealed: -Resident #4 was in her room close to the door when the Resident Care Director (RCD) entered the resident's room. -The RCD checked Resident #4's blood sugar at 12:08pm and it was 253. -The RCD stated that she had to prime the Novolog FlexPen with 2 units to get rid of any air	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 358	Continued From page 16	D 358		

bubbles.
-The RCD prepared Resident #4's Novolog FlexPen without an attached needle by holding the pen up, then turned the dial of the flex pen to 2 units and pressed the button of the flex pen to disperse 2 units.
-The RCD then attached a needle onto the Novolog FlexPen, then turned the dial to 6 units.
-The RCD administered 6 units of Novolog in Resident #4's right upper outer arm.

Review of Resident #4's November 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog FlexPen sliding scale before meals. 201 -250 give 4 units, 251 - 300 give 6 units, 301-350 give 8 units, 351 - 400 give 10 units and greater than 400, give 10 units and call the PCP with a scheduled administration time at 7:15am, 11:45am, and 4:45pm with a space to documents the amount given and the fingerstick blood sugar results.
-There was documentation Resident #4's fingerstick blood sugar was 253 and 6 units of Novolog was administered on 11/17/21.

Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 11/17/21 at 4:08pm revealed:
-It was required prior to administering Resident #4's Novolog insulin in the FlexPen to prime the pen with 2 units of insulin with the needle on to observe the insulin come out of the needle prior to each use.
-It was required important to expel 2 units to the end of the needle to ensure there was nothing wrong (no defects) in the pen and the needle prior to administering Resident #4's Novolog.

Interview with the RCD on 11/17/21 at 3:34pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 358	Continued From page 17 revealed: -She was not aware the needle had to be attached to Resident #4's Novolog FlexPen when priming the pen to remove air bubbles. -Resident #4's insulin needle was very small. -She knew Resident #4's Novolog FlexPen was primed with all air bubbles removed because she observed a small amount of insulin come out the end of the pen when she pressed the button to dispense the 2 units of Novolog in the air. -She was not aware the insulin needle to the Novolog FlexPen should have been attached to the pen when priming and removing the air to ensure there was no air or defects in the needle. Refer to the interview with the Administrator on 11/17/21 at 5:20pm. _____ Interview with the Administrator on 11/17/21 at 5:20pm revealed he expected the MAs to ensure the residents' medications were administered as ordered.	D 358		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure prescription medications including controlled substances were	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 378	Continued From page 18	D 378		

locked when not under the direct physical supervision of a medication aide.

The findings are:

Observation of the dining room on 11/16/21 at 12:37pm revealed:
-There was a clear plastic medication crush sleeve on the dining room floor between two tables.
-There was a pink and white powdered substance with small white particles in the sleeve.
-There was a small white particle on the floor beside the mediation crush sleeve.
-There were greater than 20 residents in the dining room.
-There was a medication aide (MA) standing on the opposite side of the dining room than crushed medications in the plastic medication sleeve which was on the floor.

Interview with the MA on 11/16/21 at 12:40pm revealed:
-The medication sleeve contained a resident's crushed medications from the 8:00am medication pass today, 11/16/21.
-She placed the resident's crushed medications in her pocket because the resident was asleep when she went to administer the resident's medications.
-She was going to attempt to administer the resident's medications later but forgot.
-The medication sleeve that contained the resident's medications fell out of her pocket during lunch today, 11/16/21.

Interview with the Administrator on 11/16/21 at 12:53pm revealed:
-He did not expect the MA to store the resident's crushed medications in a crush sleeve in her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

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D 378	Continued From page 19	D 378		

pocket because the MA could have forgotten who the medications were prepared for.
-The crushed medications should have been mixed in applesauce or pudding and locked on the medication cart and the MA attempted twice more to administer.
-He expected the MA to dispose of the medications if not administered.
-He was unsure of how the crushed medications should have been disposed of if not administered.
-There were confused and wandering residents who lived in the facility.
-It was dangerous for medications to be on the floor and unsecured because a resident could find the medications and swallow them.

Second interview with the MA on 11/16/21 at 1:00pm revealed:
-The medication crush sleeve found on the dining room floor today, 11/16/21 during lunch contained a resident's 8:00am Aspirin, Lexapro, Synthroid, Lorazepam, Tramadol, Vitamin B-12, and Vitamin D3.
-She should have locked the resident's crushed medications in the medication cart when she realized the resident was asleep instead of placing them in her pocket.
-She never should have stored the resident's crushed medications in her pocket.
-She did not realize the resident's crushed medications had fallen from her pocket today, 11/16/21.
-She was concerned another resident could have found and taken the resident's crushed medications discovered on the dining room floor during lunch today, 11/16/21.
-There were confused and ambulatory residents in the dining room today, 11/16/21, during lunch.

Interview with the MA Supervisor (MA/S) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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
D 378	Continued From page 20 11/16/21 at 3:56pm revealed the MA should not have stored crushed medications in her pocket because another resident could have found and swallowed the medications. Attempted telephone interview with the resident's Primary Care Provider (PCP) on 11/17/21 at 4:02pm was unsuccessful.	D 378		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care and storage of medications. The findings are: Based on observations, interviews, and record reviews the facility failed to ensure the health care needs of 2 of 5 sampled residents (#3, #6) were met related to include a resident who had irregular breathing (#6) and scheduling a urology appointment (#3). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		