

Rec'd 5/8/25

PRINTED: 05/08/2025
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER THE OAKS OF ALAMANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 1670 WESTBROOK AVENUE BURLINGTON, NC 27215		
(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 and follow-up survey on 04/15/25-04/16/25.	D 000			
D 049	10A NCAC 13F .0305 (d) Physical Environment 10A NCAC 13F .0305 Physical Environment (d) The requirements for the bedroom are: (1) the number of resident beds set up shall not exceed the licensed capacity of the facility; (2) live-in staff shall be permitted in facilities with a capacity of 7 to 12 residents provided all of the requirements of Section .0600 of these Rules are met; (3) there shall be separate bedrooms for any live-in staff and other persons living in the facility. Residents shall not share bedrooms with live-in staff and other live-in non-residents; (4) live-in staff shall not occupy a licensed bed or live in a licensed bed; (5) residents shall reside in bedrooms with residents of the same sex unless other arrangements are made with each resident's consent; (6) only rooms authorized by the Division of Health Service Regulation as bedrooms shall be used for bedrooms; (7) bedrooms shall be located on an outside wall and off a corridor. A room where access is through a bathroom, kitchen, or another bedroom shall not be approved as a resident's bedroom; (8) private resident bedrooms shall have not less than 100 square feet of occupiable floor area excluding accessory areas such as vestibules, closets, or wardrobes. For the purpose of this Rule, "private resident bedroom" is a resident bedroom occupied by one resident; (9) semi-private resident bedrooms shall have	D 049	D049 Window Repaired 4/23/2025. The handyman checked all rooms for additional needs and will continue this practice every week, unless otherwise informed of any necessary repairs. (Complete Date 6/2/2025)		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

61TV41

If continuation sheet 1 of 43

[Signature] 5/20/25

Reviewed and acknowledged 05/21/25. *kg*

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE OAKS OF ALAMANCE

**1670 WESTBROOK AVENUE
BURLINGTON, NC 27215**

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D 049	Continued From page 1 not less than 80 square feet of occupiable floor area per bed excluding accessory areas such as vestibules, closets, or wardrobes. For the purpose of this Rule, "semi-private resident bedroom" is a resident bedroom occupied by two residents; (10)the total number of residents assigned to a bedroom shall not exceed the number authorized by the Division of Health Service Regulation for that particular bedroom; (11)a bedroom may not be occupied by more than two residents; (12)resident bedrooms shall be designed to accommodate all required furnishings; (13)resident bedrooms shall be ventilated with one or more windows which are maintained operable. The window area shall not be less than eight percent of the floor space and be equipped with insect-proof screens. The window opening may be restricted to a six-inch opening to inhibit resident elopement or suicide. The windows shall be low enough to see outdoors from the bed and chair, with a maximum 36 inch sill height; and (14)Residents' bedrooms shall have one closet or wardrobe per resident. A closet or wardrobe shall have clothing storage space of not less than 48 cubic feet per bed, approximately two feet deep by three feet wide by eight feet high, of which one-half of this space shall be for hanging with an adjustable height hanging bar. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that a window in a resident room was operable for 1 of 37 resident rooms (101). The findings are:	D 049		

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D 049	Continued From page 2 Observation of room 101 on 04/15/25 at 8:15am revealed: -There were two residents that resided in the room. -The room was cool. -One of the two windows was open about six inches. -The window did not have a screen. -The window crank used to open and close the window was broken off. -The window could not be closed from inside the room. Interview with one of the residents that resided in room 101 on 04/16/25 at 10:05am revealed: -The window crank was broken when he moved into the room. -The window did not have a screen. -He did not tell anyone the window was broken. -He thought the facility staff should have noticed the window was broken and fixed it. -He was cold in the room this morning and would have liked to have been able to close the window. Interview with a second resident that resided in room 101 on 04/16/25 at 11:07am revealed: -He had been in room 101 for about 2 months and the window was broken since then. -The window had not had a screen since he moved into the room. -He thought the window should have been fixed. Interview with a personal care aide (PCA) on 04/16/25 at 11:05am revealed she had not noticed the window in room 101 did not have a crank to open or close the window and did not have a screen. Interview with the housekeeper on 04/16/25 at 11:07am revealed:	D 049		

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D 049	Continued From page 3 -The Maintenance Director had a book that she could write things in that needed to be repaired, but he preferred to be verbally told if there was a problem. -She did not know the window crank in room 101 was broken and did not have a screen. -Interview with the Maintenance Director on 04/16/25 at 11:00am revealed: -He was the only one that worked in maintenance. -The housekeepers usually told him when something needed to be repaired. -He did not have a schedule for how often he went into the resident rooms and checked for things that needed to be repaired. -He had not been told about the window in room 101. -He was not aware the window crank in room 101 was broken off and the window did not have a screen. Interview with the Administrator on 04/16/25 at 3:02pm revealed: -He did not know how often the Maintenance Director made rounds into the resident rooms to check for concerns. -He was concerned no one noticed the window crank did not work and the window did not have a screen in room 101. -He was concerned the window did not get fixed. -He expected the windows in the resident rooms to be operable.	D 049		
D 056	10A NCAC 13F .0305 (f)(5) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and	D 056	D056 4/16/2025 Chemicals in SCU were disposed of or placed in a locked room on 4/17/2025 4/16/2025 Families notified of all chemicals needing to go into the locked room Going forward, as of April 18, 2025, since the survey, weekly room checks will be performed by the memory care coordinator as needed. A policy notification has been placed at the SCU door for families. (Complete Date - 6/2/2025)	

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D 056	Continued From page 4 closets are: (5) the requirements for housekeeping storage are: (A) a housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof. In multi-level facilities, each resident floor shall have a housekeeping closet; and (B) there shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled, or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that substances that may be hazardous were kept in a separate locked area and not accessible to residents in the Special Care Unit (SCU). The findings are: Review of the facility's chemical policy (undated) revealed: -Chemicals purchased by the facility, must be stored in locked rooms, including disinfectant spray. -Chemicals found not to be purchased by the facility, were subject to notification of family to remove the items or destroy the item with no compensation to the purchaser. Observation of a resident's room on 04/15/25 at 8:17am revealed: -There was a bottle of disinfectant. -The warnings on the disinfectant label included storage in areas inaccessible to small children.	D 056		

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D 056	Continued From page 5 Hazardous to humans and domestic animals. Causes moderate eye irritation. Avoid contact with clothes or eyes. There were first aid directions if the disinfectant came in contact with the eyes, skin, or clothing. -There was a can of shaving cream; the warning label included keeping out of reach of children. -There was a tube of after-shave lotion; the warning label was to avoid contact with eyes. -There was a bottle of a full-body cleanser. -The warnings on the label included for external use only. Avoid contact with eyes. Keep out of reach of children. Observation of a second resident room on 04/15/25 at 8:19am revealed: -There was a bottle of hydrogen peroxide (mild antiseptic used on the skin to prevent infection of minor cuts, scrapes, and burns) sitting on an open shelf. -The warnings on the hydrogen peroxide label included external use only. Do not use it in the eyes. Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away. -There were multiple bottles of moisturizing lotion for sensitive skin. -The warnings on the labels included for external use only, Avoid contact with eyes. Keep out of reach of children. -There were multiple bottles of mouthwash. -The warning labels included keeping out of reach of children. If more than used for rinsing is accidentally swallowed, get help or contact a poison control center right away. Observation of a third resident room on 04/15/25 at 8:21am revealed: -There was a bottle of cornstarch powder on the bedside table.	D 056			

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D 056	Continued From page 6 -The warnings on the label included avoiding contact with the eyes. For external use only. Do not use it on broken skin. Keep away from the face to avoid inhalation, which could cause breathing problems. Keep out of reach of children. -There was a bottle of citrus-fragrant hand sanitizer. -The warnings on the label included for external use only. When using this product keep out of eyes, ears, and mouth. If it comes in contact with the eyes, rinse thoroughly with water. Keep out of reach of children. If swallowed get medical help or contact a poison Control Center. Supervise children under six years of age when using this product to avoid swallowing or putting on the face. Do not use it on open wounds or broken skin. Observation of a fourth resident's room on 04/15/25 at 8:40am revealed: -There was a bottle of fingernail polish remover sitting on the bedside table. -The warnings on the fingernail polish remover included to keep out of the eyes. In case of eye contact, immediately flush the eyes with water for at least 15 minutes. Contact a physician. Harmful if ingested. In case of accidental ingestion, give fluids liberally and consult with the local poison control center. Keep out of reach of children. -There was a spray bottle of disinfecting spray. -The warnings included caused moderate eye irritation. Do not spray in the eyes, on the skin, or on clothing. Wash thoroughly with soap and water and handling and before eating, drinking, chewing gum, using tobacco, or using the toilet. Observation of a fifth resident's room on 04/15/25 at 1:51pm revealed: -There was a container of petroleum jelly sitting	D 056			

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D 056	Continued From page 7 on an open shelf. -The warnings on the container of petroleum jelly included for external use only, do not get into the eyes. Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away. -There were bottles of hairspray, lotions, and creams; they all had warning labels. Observation of multiple other residents' rooms on 04/15/254 at various times from 8:15am-2:00pm revealed shampoos, lotions, body washes, deodorants, and hairspray cans on open shelves in resident bathrooms and residents' bedside tables. Observation of the SCU living room on 04/15/25 at 2:40pm revealed: -The resident entered the living room and was noted to have a white cream covering her lips and teeth. -A personal care aide (PCA) smelled the white substance and stated it smelled like toothpaste. Interview with a PCA on 04/15/25 at 2:11pm revealed: -Multiple [named] residents wandered into other residents' rooms. -Residents could keep their personal items on shelves in the room, the dresser tops, or in the bathroom. Interview with a second PCA on 04/15/25 at 2:16pm revealed: -Multiple [named] residents wandered within the SCU. -One [named] resident was observed eating a crayon one time. -Another [named] resident was observed eating ChapStick.	D 056		

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D 056	Continued From page 8 -A third [named] resident would pick things off the floor and put them in her mouth; she would say she was checking to see if it was candy. Interview with a medication aide (MA) on 04/15/25 at 2:30pm revealed: -Residents could keep personal items in their room such as lotions, mouthwash, and hairspray. -All cleaning items needed to be locked up. Interview with the SCU Coordinator on 04/15/25 at 2:41pm revealed: -Deodorizing sprays were usually not kept in resident rooms, "we try to keep those in the medication room." -Some of the residents could mistake the spray for something besides its intended use. -Residents could keep mouthwash, shaving creams, and such in their bathrooms for use. -A [named] resident used to shave himself but now he was not able to and the shaving cream should not be in his room because the resident might not know what to do with it. Interview with the Administrator on 04/15/25 at 2:50pm revealed: -Items such as disinfectant sprays should be locked in the office or on the housekeeping cart. -These items could be dangerous if ingested, or even if a resident got a spray on their skin, it could cause problems. -Personal items such as lotions and mouthwash were kept in the resident rooms and were not locked. Telephone interview with the facility's contracted primary care provider (PCP) on 04/16/25 at 11:48am revealed anything that was labeled to keep out of reach of children, should not be accessible to a resident in a SCU without	D 056		

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D 056	Continued From page 9 supervision of its use.	D 056		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain the facility free of hazards for 2 of 2 resident rooms (Room 122 and Room 207) related to oxygen tanks not properly stored by being secured in a storage crate or cart. The findings are: 1. Observation of room 122 on 04/15/25 at 8:45am revealed: -There were 23 oxygen tanks in the room. -There were 3 small oxygen tanks that were not secured in a cart or crate. -There were 4 large oxygen tanks that were not secured in a cart or crate. Interview with one of the residents in room 122 on	D 079	D079 4/18 Received Metal Oxygen brackets, purchased at facility expense. DME reported that they only have plastic. DME removed 2/3 of the extra oxygen—monthly monitoring by RCD and ED. (Complete Date 6/2/2025)	

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D 079	Continued From page 10 04/15/25 at 8:45am revealed: -He did not use oxygen anymore. -He did not know why the oxygen was still in the room. -The oxygen tanks took up a lot of room and he wanted them removed. Telephone interview with a representative from the facility's contracted medical supply company on 04/15/25 at 12:32pm revealed: -Oxygen tanks should be kept upright. -It was preferable that oxygen tanks were secured in a crate or cart. -Storing them in a cart or crate prevented them from tipping over and causing potential injuries. Interview with a personal care aide (PCA) on 04/15/25 at 1:45pm revealed she just started and was not sure how oxygen tanks should be stored. Interview with the medication aide (MA) on 04/15/25 at 1:55pm revealed the resident in room 122 did not use oxygen. Refer to interview with a personal care aide (PCA) on 04/15/25 at 1:45pm. Refer to interview with the medication aide (MA) on 04/15/25 at 1:55pm. Refer to interview with the Resident Care Coordinator on 04/15/25 at 1:58pm. Refer to interview with the Administrator on 04/15/25 at 3:02pm. 2. Observation of room 207 on 04/15/25 at 8:30am revealed: -There were 6 oxygen tanks in the room. -There were 5 oxygen tanks in the left corner of	D 079		

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D 079	Continued From page 11 the room not secured in a crate or cart. -There was an oxygen tank laying parallel across a walker. Interview with the resident who resided in room 207 on 04/16/25 at 8:55am revealed: -He had never tripped or fallen over the oxygen tanks. -He kept them lined up against the wall to keep them from falling. -He was not aware the tanks should be kept in a crate or cart to prevent them from falling. Refer to interview with a personal care aide (PCA) on 04/15/25 at 1:45pm. Refer to interview with the medication aide (MA) on 04/15/25 at 1:55pm. Refer to interview with the Resident Care Coordinator on 04/15/25 at 1:58pm. Refer to interview with the Administrator on 04/15/25 at 3:02pm. Interview with a personal care aide (PCA) on 04/15/25 at 1:45pm revealed she just started and was not sure how oxygen tanks should be stored. Interview with the medication aide (MA) on 04/15/25 at 1:55pm revealed: -The oxygen tanks should be stored in a cart, so they didn't tip over. -The oxygen tanks were heavy and could hurt someone if one fell over. Interview with the Resident Care Coordinator on 04/15/25 at 1:58pm revealed: -Oxygen tanks should be stored upright in a rack. -Oxygen tanks should be out of the way, so a	D 079		

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D 079	Continued From page 12 resident did not trip on them. -If an oxygen tank fell over, it could injure someone. Interview with the Administrator on 04/15/25 at 3:02pm revealed: -All oxygen tanks should be stored upright in a cart or crate. -There were not enough carts to store the oxygen tanks. -Oxygen tanks should be stored in carts so they did not tip over and injure anyone.	D 079		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to implement physician's orders for 1 of 5 sampled residents (#5) related to an order for compression stockings. The findings are: Review of Resident #5's current FL-2 dated 07/30/24 revealed: -Diagnoses included dementia, congestive heart disease, and hypertension. -Resident #5 required assistance with bathing	D 276		

*D276 Starting April 17, 2025,
as part of the weekly audits
by RCD, monitor usage.
(Complete Date 6/2/2025)*

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER THE OAKS OF ALAMANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 1670 WESTBROOK AVENUE BURLINGTON, NC 27215		
(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 276	Continued From page 13 and dressing. Review of Resident #5's signed physician's orders dated 11/30/24 revealed an order for below knee compression stockings. Review of Resident #5's after-visit summary dated 02/04/25 revealed: -Resident #5 appeared dehydrated with a low blood pressure. -Advise leg elevation and compression stockings. -Plan for conservative management of chronic kidney disease. Review of Resident #5's after-visit summary dated 03/02/25 revealed: -Resident #5 had hypertensive heart and stage 4 chronic kidney disease with congestive heart failure. -Resident #5 had +2 edema to the right lower leg and +3 edema to the left lower leg. -Orders for the visit included measurements for compression stockings with directions to apply them in the morning and remove them at bedtime. Review of Resident #5's signed physician's orders dated 03/18/25 revealed an order for below knee compression stockings, apply in the morning and remove at bedtime. Hand wash in the sink and lay out to dry overnight. Review of Resident #5's care plan dated 03/13/25 revealed he required limited assistance with bathing, dressing, toileting, and grooming. Observation of Resident #5 on 04/15/25 at 8:50am and 12:25pm revealed: -He was wearing a pair of mid-calf white cotton socks.	D 276			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/16/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE OAKS OF ALAMANCE

**1670 WESTBROOK AVENUE
BURLINGTON, NC 27215**

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D 276	Continued From page 14 -He had indentations on his legs where the socks stopped. -The socks were not compression stockings. Interview with Resident #5 on 04/15/25 at 12:26pm revealed: -He was supposed to wear compression stockings every day. -He wore compression stockings yesterday, 04/14/25. -The socks he wore were "tight" but not like "the other ones." Observation of Resident #5 on 04/16/25 at 8:53am revealed: -He was wearing a pair of below-the-knee white cotton socks. -He had indentations on his legs where the socks stopped; the left leg had deep indentations. -The socks were not compression stockings. Review of Resident #5's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for compression stockings, apply in the morning, remove at bedtime with a scheduled application time of 8:00am. -There was documentation Resident #5's compression stockings were applied at 8:00am and removed at 8:00pm on 02/01/25-02/28/25. Review of Resident #5's March 2025 (eMAR) revealed: -There was an entry for compression stockings, apply in the morning, remove at bedtime with a scheduled application time of 8:00am. -There was documentation Resident #5's compression stockings were applied at 8:00am and removed at 8:00pm on 03/01/25-03/31/25.	D 276		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/16/2025
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D 276	Continued From page 15 Review of Resident #5's April 2025 (eMAR) revealed: -There was an entry for compression stockings, apply in the morning, remove at bedtime with a scheduled application time of 8:00am. -There was documentation Resident #5's compression stockings were applied at 8:00am and removed at 8:00pm on 04/01/25-04/16/25. Telephone interview with a pharmacist with the facility's contracted pharmacy on 04/16/25 at 9:50am revealed: -A pair of compression stockings were dispensed on 04/04/25 for Resident #5. -There had been no other compression stockings dispensed for Resident #5. -The order was from a progress note dated 04/02/25. -Compression stockings were used to decrease swelling and if the resident was not wearing them as ordered he could experience increased swelling. Interview with Resident #5 on 04/16/25 at 8:53am revealed: -He put on his socks today, 04/16/25. -He did not need assistance putting his socks on. -He had a pair of "hard to put on ones, they were tight" but he did not know where they were. Observation of Resident #5 on 04/16/25 at 8:55am revealed he looked through two drawers with miscellaneous socks, but he did not locate a pair of compression stockings. Interview with a personal care aide (PCA) on 04/16/25 at 11:15am revealed: -When she came in on the first shift, Resident #5 should already have his compression stockings on; third shift staff were supposed to put them on.	D 276			

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D 276	Continued From page 16 -She did not do a walk through on first shift, so she did not know if Resident #5 was wearing compression stockings or not. -She did not check Resident #5 on 04/15/25 or 04/16/25 to ensure he wore compression stockings. Interview with a medication aide (MA) on 04/16/25 at 10:49am revealed: -Third shift staff were responsible for applying Resident #5's compression stockings in the morning. -The MA and the PCA on the first shift should check to ensure the resident had the compression stockings on. -She did not check Resident #5's stockings to ensure he wore his compression stockings on 04/15/25. -She did not know Resident #5 was not wearing compression stockings on 04/15/25 or 04/16/25. Observation of Resident #5 on 04/16/25 at 11:13am revealed he was wearing compression stockings. Telephone interview with Resident #5's primary care provider (PCP) on 04/16/25 at 11:48am revealed: -Compression stockings were ordered for Resident #5 for edema. -If Resident #5 did not wear his compression stockings as ordered his edema could get worse. -Resident #5 had horrible edema, which could not be treated effectively with oral medications due to kidney problems. -She expected Resident #5's compression stockings to be applied as ordered and if the resident refused, she should be notified. Telephone interview with Resident #5's family	D 276		

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D 276	Continued From page 17 member on 04/16/25 at 12:53pm revealed: -Resident #5 wore "special stockings" for swelling. -A couple of weeks ago, she recalled Resident #5 did not have his compression stockings on and she brought it to the attention of a staff member. -The staff member found Resident #5's compression stockings in his drawer. -She told the staff member that Resident #5 was not able to put the compression stockings on himself and staff needed to do it. Telephone interview with a MA on 04/16/25 at 1:52pm revealed: -Resident #5's compression stockings were scheduled to be applied around 5:00am. -Resident #5 could not apply his compression stockings correctly so staff would need to apply the compression stockings. -She did not know if the PCA applied Resident #5's compression stockings on 04/15/25 or 04/16/25. Telephone interview with the PCA on 04/16/25 at 4:01pm revealed: -Resident #5 put his compression stockings on himself. -She double checked to ensure Resident #5 had put his compression stockings on. -Resident #5 had his compression stockings on 04/15/25 and 04/16/25. -She did not know what happened after she left. Interview with the special care unit (SCU) Coordinator on 04/16/25 at 11:32am revealed: -Resident #5's compression stockings should be applied by the third shift staff when he first woke up in the morning. -The staff on the first shift should check to make sure the resident had the compression stockings	D 276			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/16/2025
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D 276	Continued From page 18 on. -She did not know Resident #5 did not have his compression stockings on 04/15/25. -She put Resident #5's compression stockings on, today, 04/16/25; she did not recall what time. -She expected Resident #5's compression stockings to be applied as ordered. Telephone interview with the Administrator on 04/16/25 at 4:03pm revealed: -He expected staff to apply Resident #5's compression stockings as ordered. -He observed Resident #5 wearing compression stockings at 9:00am on 04/16/25. Attempted telephone interview with the facility's licensed health professional support (LHPS) nurse on 04/16/25 at 1:51pm was unsuccessful.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure therapeutic diets were served as ordered for 2 of 2 sampled residents with a diet order for chopped meats (#3, #5) and a nutritional supplement (#1). The findings are: 1. Review of Resident #3's current FL-2 dated	D 310	D310 House shake is on the MAR as of April 17, 2025, with review from the pharmacy. RCD and ED will complete a dietary review. (Complete Date 6/2/2025)	

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D 310	Continued From page 19 03/03/25 revealed: -Diagnoses included type 2 diabetes, retention of urine, hypertension, and hyperlipidemia. -There was no diet listed. Review of Resident #3's signed physician orders dated 03/03/25 revealed an order for a no concentrated diet (NCS), chopped meats diet. Observation of Resident #3's breakfast meal service on 04/15/25 at 8:14am revealed: -Resident #3 was served a sausage patty; the sausage patty was not chopped. -Resident #3 ate 100% of the sausage patty. Observation of Resident #3's breakfast meal service on 04/16/25 at 8:08am revealed: -Resident #3 was served a strip of bacon; the strip of bacon was not chopped. -Resident #3 ate 100% of the bacon strip. Telephone interview with Resident #3's family member on 04/16/25 at 12:36pm revealed: -She had been with Resident #3 when his meal was served. -Resident #3's meats were not served chopped for the meals she observed. -She observed Resident #3 cut his meats up himself. -Resident #3 did not have teeth. -She had observed Resident #3 cut his meat up, chew it a "couple" of times, and then swallow. Interview with a personal care aide (PCA) on 04/16/25 at 11:15am revealed: -Resident #3's meat was supposed to come from the kitchen chopped up. -She had told the special care unit (SCU) Coordinator that Resident #3's meat was not chopped up from the kitchen.	D 310		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/16/2025
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D 310	Continued From page 20 -When Resident #3's meat was not chopped the resident would cut the meat up himself. -Resident #3 did not like anyone to cut up his food for him. Interview with a medication aide (MA) on 04/16/25 at 10:49am revealed: -The SCU Coordinator told her "Who could eat what." -She was not aware Resident #3 had an order for chopped meats. -She had not observed Resident #3 have any problems with chewing meat. Interview with the SCU Coordinator on 04/16/25 at 11:32am revealed no one had told her Resident #3's meats were not being chopped in the kitchen. Telephone interview with Resident #3's primary care provider (PCP) on 04/16/25 at 11:48am revealed: -Resident #3's diet order for chopped meats was due to poor dentition (inadequate or missing teeth) which could cause the resident to be unable to chew meats. -Some meats could be more difficult to chew than other meats. -If the resident's meats were not cut up, the resident could get choked or not eat his meal completely. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. Attempted interview with the Dietary Manager (DM) on 04/16/25 at 2:30pm was unsuccessful. 2. Review of Resident #5's current FL-2 dated	D 310		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/16/2025
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D 310	Continued From page 21 07/30/24 revealed: -Diagnoses included dementia and congestive heart disease. -There was no diet order listed. Review of Resident #5's signed physician orders dated 07/30/24 revealed an order for chopped meats. Observation of Resident #5's breakfast meal service on 04/15/25 at 8:14am revealed: -Resident #5 was served a sausage patty; the sausage patty was not chopped. -Resident #5 ate 100% of the sausage patty. Observation of Resident #5's breakfast meal service on 04/16/25 at 8:08am revealed: -Resident #5 was served a strip of bacon; the strip of bacon was not chopped. -Resident #5 ate 100% of the bacon strip. Interview with Resident #5 on 04/16/25 at 9:22am revealed: -He had dentures. -If the meat was cooked "right" he could eat it okay. -His meat was not served cut up, but he could cut the meat up himself. -"I cut up what needed cutting." Telephone interview with Resident #5's family member on 04/16/25 at 12:53pm revealed: -She had been with Resident #5 when his meal was served. -She observed Resident #5 cut his meats up himself. -Resident #5 had dentures and if the meat was not too tough or chewy the resident did "okay." Interview with a personal care aide (PCA) on	D 310		

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D 310	Continued From page 22 04/16/25 at 11:15am revealed: -Resident #5's meat was supposed to come from the kitchen chopped up. -She had told the special care unit (SCU) Coordinator that Resident #5's meat was not delivered chopped up from the kitchen. -When Resident #5's meat was not chopped the resident would cut the meat up himself. -Resident #5 did not like anyone to cut up his food for him. Interview with a medication aide (MA) on 04/16/25 at 10:49am revealed: -The SCU Coordinator told her "Who could eat what." -She was not aware Resident #5 had an order for chopped meats. -She had not observed Resident #5 have any problems with chewing meat. Interview with the SCU Coordinator on 04/16/25 at 11:32am revealed no one had told her Resident #5's meats were not being chopped in the kitchen. Attempted telephone interview with Resident #5's primary care provider (PCP) on 04/16/25 at 12:49pm was unsuccessful. Attempted interview with the Dietary Manager (DM) on 04/16/25 at 2:30pm was unsuccessful. Interview with the SCU Coordinator on 04/16/25 at 11:32am revealed: -A resident with an order for chopped meats, the meat should be chopped in the kitchen. -If the resident with an order for chopped meats did not receive chopped meats, the staff should contact someone in dietary to let them know. -No one had told her Resident #3's meats were	D 310		

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D 310	Continued From page 23 not being chopped in the kitchen. -There was a reason the PCP ordered a chopped diet. -If the meat was not chopped, the resident may have a hard time with the consistency. Interview with the Administrator on 04/16/25 at 3:02pm revealed: -It was the cook's job to ensure the diets were served correctly. -The PCAs should know each resident's diet and if the meal was not served correctly they should ask the MA to confirm the diet order. -If the diet was not sent from the kitchen correctly, the PCA should notify the kitchen. -He was concerned because if the meat was not chopped as ordered, the resident could have a choking episode. 3. Review of Resident #1's current FL2 dated 02/04/25 revealed diagnoses including mild cognitive impairment, benign prostatic hypertrophy, and failure to thrive. Review of a progress note by Resident #1's primary care provider (PCP) dated 02/18/25 revealed a new order for a nutritional supplement daily between or with a meal of choice. Review of Resident #1's February 2025 electronic medication administration record (eMAR) from 02/18/25 to 02/28/25 revealed there was no entry for a nutritional supplement for Resident #1. Review of Resident #1's March 2025 eMAR revealed there was no entry for a nutritional supplement for Resident #1. Review of Resident #1's April 2025 eMAR from 04/01/25 to 04/15/25 revealed there was no entry	D 310		

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D 310	Continued From page 24 for a nutritional supplement for Resident #1. A telephone interview with a representative from the facility's contracted pharmacy on 04/16/25 at 1:55pm revealed there was no order for Resident #1 to have a nutritional supplement. Interview with Resident #1 on 04/16/25 at 10:05am revealed: -He was not aware there was an order for him to have a nutritional supplement; he did not know anything about it. -He did not think he was getting enough food to eat. Interview with a medication aide (MA) on 04/16/25 at 8:50am revealed: -If a resident had an order for a nutritional supplement, it would be on the eMAR. -Resident #1 did not have an order for a nutritional supplement on the eMAR. -She had never given Resident 1 a nutritional supplement. Interview with a Resident #1's PCP on 04/16/25 at 11:45am revealed: -She ordered the nutritional supplement for Resident #1 shortly after he was admitted in February 2025 because she was unsure of his nutritional status prior to admission and she wanted to make sure he was getting enough nutrition. -When she wrote orders on the after visit summary, she faxed them to the facility. -She did not know who received the faxes at the facility. -She was not aware the nutritional supplement for Resident #1 was not ordered. -She was not too concerned about the nutritional supplement as Resident #1 was eating well and	D 310		

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D 310	Continued From page 25 going to the dining room for meals. -She expected orders to be followed. Interview with the Resident Care Coordinator (RCC) on 04/16/25 at 2:15pm revealed: -She faxed the orders from the PCP to the pharmacy, waited for them to input them into the eMAR system and then she approved them. -She stamped the progress notes after she faxed them to the pharmacy. -Resident #1's after visit summary from 02/18/25 that contained the order for the nutritional supplement for Resident #1 was not stamped or signed. -She did not know how the order for the nutritional supplement for Resident #1 got missed. Interview with the Administrator on 04/16/25 at 3:02pm revealed: -The RCC was responsible for making sure all orders by the PCP were carried out. -The order for the nutritional supplement for Resident #1 should have been faxed to the pharmacy and put on the eMAR.	D 310			
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.	D 358	D358 consulted with the provider and the pharmacy to clarify and adjust the order. The order was updated on MAR by the pharmacy on 4/16/2025. Weekly med review by RCD. (Complete Date 6/2/2025)		

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THE OAKS OF ALAMANCE

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BURLINGTON, NC 27215**

(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 26 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents (#5) related to a medication used to treat fluid retention. The findings are: Review of the facility's medication policy (undated) revealed: -Orders were to be faxed to the pharmacy for transcribing and for the medication to be sent to the facility. -If an order was not clear or complete, notify the primary care provider (PCP). Review of Resident #5's current FL-2 dated 07/30/24 revealed diagnoses included dementia, congestive heart disease, and hypertension. Review of Resident #5's signed physician's order dated 04/02/25 revealed an order for Torsemide (used to help treat fluid retention (edema) and swelling that is caused by congestive heart failure, liver disease, kidney disease) 10mg, hold for systolic blood pressure (SBP) of less than 110. Review of Resident #5's signed physician's order dated 04/08/25 revealed an order to stop Torsemide 10mg and start Torsemide 5mg. Review of Resident #5's April 2025 electronic medication administration record (eMAR) from 04/02/25-04/16/25 revealed: -There was an entry for Torsemide 10mg once daily with a scheduled administration time of 8:00am; hold for SBP of less than 110. -There was documentation that Torsemide 10mg	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/16/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE OAKS OF ALAMANCE

**1670 WESTBROOK AVENUE
BURLINGTON, NC 27215**

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D 358	Continued From page 27 was administered on 04/05/25-04/15/25 at 8:00am; there were no blood pressures (BP) documented. -There was a second entry for Torsemide 5mg once daily with a scheduled administration time of 8:00am. -There was documentation that Torsemide 5mg was administered on 04/12/25-04/16/25 at 8:00am. Observation of Resident #5's medications on hand on 04/15/25 at 9:26am revealed: -There was a multidose pouch that contained a Torsemide 10mg and a Torsemide 5mg. -There was also a punch card dispensed on 04/11/25 that contained six tablets of Torsemide 5mg; three tablets remained on the punch card. Telephone interview with a pharmacist with the facility's contracted pharmacy on 04/16/25 at 9:50am revealed: -Resident #5 currently had two doses of Torsemide. -Torsemide 10mg was dispensed on 04/04/25 and Torsemide 5mg was added on 04/11/25. -An electronic prescription (escript) for Torsemide 5mg was received and no accompanying note to discontinue the Torsemide 10mg. -Resident #5's after-visit summary dated 04/08/25 was not received at the pharmacy. -If the after-visit summary dated 04/08/25 was received the Torsemide 10mg would have been discontinued. -Resident #5's BP should have been checked before administering the Torsemide, especially if the additional dose of Torsemide was being administered. Telephone interview with Resident #5's PCP on 04/16/25 at 11:48am revealed:	D 358		

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NAME OF PROVIDER OR SUPPLIER THE OAKS OF ALAMANCE		STREET ADDRESS, CITY, STATE, ZIP CODE 1670 WESTBROOK AVENUE BURLINGTON, NC 27215		
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D 358	Continued From page 28 -If Resident #5 was administered Torsemide 5mg and Torsemide 10mg his BP could be too low. -The facility should fax her after-visit summary to the pharmacy when she documented order changes. -Her concern would be that the Resident's BP could bottom out. Interview with a medication aide (MA) on 04/16/25 at 10:49am revealed: -She administered medications based on the eMAR. -She checked Resident #5's BP based on what the order was in the eMAR. -She had not checked Resident #5's BP daily. -Resident #5 received Torsemide 10mg and Torsemide 5mg because both doses were entered in the eMAR. -She did not realize she was supposed to take Resident #5's BP before administering the Torsemide per the eMAR entry. Interview with the special care unit (SCU) Coordinator on 04/16/25 at 11:32am revealed: -Resident #5's BP was checked every day, but it was not documented on the eMAR. -She expected the MAs to check Resident #5's BP before administering his Torsemide. -She spoke to someone at the pharmacy today, 04/16/25, and Resident #5 was supposed to get Torsemide 5mg daily. -Today, 04/16/25, was the first time she noticed Torsemide was listed twice on the eMAR. -The MAs had not told her there were two different entries for Resident #5's Torsemide. -The Resident Care Director (RCD) reviewed all the paperwork so when it was sent to her to be filed, she assumed everything had been changed as needed. -She was concerned Resident #5 was	D 358		

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D 358	Continued From page 29 administered medication that could have lowered his BP and if his BP was not checked they would not know. Interview with the RCD on 04/16/25 at 2:15pm revealed: -She reviewed the PCP's after-visit summary and faxed it to the pharmacy if there were any new orders. -The pharmacy entered the orders and she or the Administrator accepted the orders once it was confirmed as accurate. -She did not remember anything about Resident #5's Torsemide. -She did not know why Resident #5's Torsemide 10mg was not discontinued. Interview with the Administrator on 04/16/25 at 3:02pm revealed: -He looked at the eMARs once a month for holes and things not filled in. -He expected the RCD to make sure the orders were correct. -The RCD should have noticed the second entry for the Torsemide did not "drop off." -He was concerned Resident #5 could have been harmed because he was administered too much Torsemide.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication	D 367	D367, 4/25/2025: Clarified with MD about adjusting the order to make it user-friendly and easy to understand. The order was changed on April 25 to combine the amounts given, allowing staff to document it once, rather than separately, when administering insulin. (Ongoing) RCD and ED to monitor new orders for possible clarifications to prevent misunderstandings. (Complete Date 6/2/2025)	

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D 367	Continued From page 30 administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the accuracy of the electronic medication administration record (eMAR) for 1 of 5 sampled residents (#4) related to documentation of administration of insulin (an injectable medication used to help control blood sugar levels). The findings are: Review of Resident #4's current FL2 dated 04/08/25 revealed diagnoses included diabetes type 2. Review of Resident #4's physician's orders dated 04/08/25 revealed: -An order for lispro (a short acting insulin) inject 6 units subcutaneously at breakfast and lunch. -An order for lispro inject 8 units subcutaneously at dinner. -An order for lispro inject as directed per sliding	D 367			

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D 367	Continued From page 31 scale before meals for fingerstick blood sugars (FSBS): 201-250 administer 1 unit, 251-300-2 units, 301-350 administer 3 units, 351 and above administer 4 units. Review of Resident #4's April 2025 from 04/08/25 to 04/15/254 electronic medication administration record (eMAR) revealed: -There was an entry for lispro inject 6 units at breakfast and lunch. -There was an entry for lispro inject 8 units at dinner. -There was an entry for lispro inject as directed per sliding scale before meals for FSBS 201-250 administer 1 unit, 251-300-2 units, 301-350 administer 3 units, 351 and above administer 4 units. -There was documentation staff administered 1 unit of lispro on 04/09/25 for FSBS of 212. -There was documentation staff administered 4 units of lispro on 04/10/25 for FSBS of 261. -There was documentation staff administered 6 units of lispro on 04/11/25 at 12:00pm for FSBS of 340. -There was documentation staff administered 2 units lispro on 04/11/25 at 5:00pm for FSBS of 285. -There was documentation staff administered 0 units of lispro on 04/12/25 at 8:00am for FSBS of 155. -There was documentation staff administered 1 unit of lispro on 04/12/25 at 12:00pm for FSBS of 208. -There was documentation staff administered 0 units of lispro on 04/13/25 at 8:00am for FSBS of 196. -There was documentation staff administered 0 units of lispro on 04/13/25 at 12:00pm for FSBS of 158. -There was documentation staff administered 2	D 367		

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D 367	Continued From page 32 units of lispro on 04/14/25 at 8:00am for FSBS of 250. -There was documentation staff administered 6 units of lispro on 04/14/25 at 12:00pm for FSBS of 254. -There was documentation staff administered 3 units of lispro on 04/14/25 at 5:00pm for FSBS of 323. Observation of FSBS check on Resident #4 on 04/16/25 at 11:12am revealed: -Resident #4 had a plastic box that contained her glucometer and her insulin. -The sliding scale instructions were listed on the inside of the plastic box. -The medication aide (MA) collected Resident #4's FSBS. -The FSBS result was 158. -The MA administered 6 units of lispro to Resident #4. -The MA documented she administered 6 units of lispro in the eMAR. Interview with Resident #4 on 04/16/25 at 10:10am revealed: -The MAs checked her FSBS three times a day before she ate. -The MAs told her what her FSBS result was. -She knew she should receive 6 units of lispro at breakfast and lunch and 8 units of lispro at dinner. -She also received additional units of lispro based on her FSBS result. -She did not have any concerns about the amount of insulin she received. Interview with a MA on 04/16/25 at 9:15am revealed: -She was confused at first about the insulin order for Resident #4 because it was listed on the	D 367		

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D 367	Continued From page 33 eMAR twice and she was not sure what to document where. -She knew Resident #4 was to get 6 units of lispro with breakfast and lunch and 8 units of lispro at dinner regardless of the FSBS result. -She knew there was a sliding scale for Resident #4 for additional units of lispro based on her FSBS result. -When she entered the FSBS result into the eMAR, it showed how much insulin to give. Interview with a second MA on 04/16/25 at 9:50am revealed -She knew Resident #4 should get insulin at breakfast, lunch, and dinner. -Resident #4 was also on a sliding scale based on what her FSBS was. -She tried to put the right amount of insulin into the eMAR and it flagged. -She did not know why it flagged, so she made a note that she could not enter the right amount and let the Resident Care Coordinator (RCC) know. Telephone interview with Resident #4's primary care provider (PCP) on 04/16/25 at 12:00pm revealed: -Resident #4 was followed by endocrinology. -Resident #4 had FSBS that were all over the place. -The MAs should document accurate FSBS results and amount of insulin given. -She thought the order for the sliding scale should be separate from the scheduled insulin order. -Resident #4 refused insulin and was non-compliant with her diet. A telephone interview with Resident #4's endocrinologist on 04/16/25 at 12:40pm was attempted but unsuccessful.	D 367		

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D 367	Continued From page 34 Interview with the RCC on 04/16/25 at 2:15pm revealed: -She worked on the medication cart recently with Resident #4 and thought the insulin orders in the eMAR were confusing because the scheduled insulin was in the same order as the sliding scale. -She did not change the way the order was in the eMAR. -There was not a scheduled system currently to check the eMARs. -She tried to review the eMARs but did not always do it. Interview with the Administrator on 04/16/25 at 3:02pm revealed: -He randomly reviewed the eMARs and checked for holes, refusals, and things that looked incorrect. -He expected the RCC to check the eMARs and make sure they were accurate. -The insulin order for Resident #4 should be clear so it made sense to the MAs. -He expected the MAs to document accurately on the eMAR.	D 367		
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 under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by:	D 378	D378 OTCs in SCU were disposed of on 4/15/2025 4/16/2025 Families notified that no OTCs can be in the resident's room. As of April 18, 2025, and following the survey, weekly room checks will be performed by the memory care coordinator as needed. A policy notification has been placed at the SCU door for families. (Complete Date 6/2/2025)	

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D 378	Continued From page 35 Based on observations, record reviews, and interviews, the facility failed to ensure that medications were stored safely and securely for 2 of 2 sampled residents (#8, #9) who resided in the special care unit (SCU) and had over the counter (OTC) medications in their bathroom. The findings are: Review of the facility's Medication Storage policy (undated) revealed: -All prescription and non-prescription medications stored by the facility shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. -The storage areas locked for medications shall only be accessible by staff responsible for medication administration, the Administrator, or the Administrator in charge. -Medications intended for topical external use shall be stored in the designated area separate from the medication intended for oral and injectable use. 1. Review of Resident #8's current FL-2 dated 08/09/24 revealed: -Diagnoses included Alzheimer's disease. -She was constantly disoriented. -The level of care was Special Care Unit (SCU). -There was no order for Resident #8 for self-administration of medications. Observation of a shared bathroom for Residents #8 and #9 on 04/15/24 at 8:41am revealed there was a tube of hydrocortisone (topical steroid cream) and Neosporin (a triple active ingredient antibacterial and pain-relieving ointment) on the residents' bathroom counter.	D 378		

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D 378	Continued From page 36 Based on observations, interviews, and record reviews, it was determined Resident #8 was not interviewable. Refer to the interview with a personal care aide (PCA) on 04/15/25 at 2:11pm. Refer to the interview with a second PCA on 04/15/25 at 2:16pm. Refer to the interview with the medication aide (MA) on 04/15/25 at 2:30pm. Refer to the interview with the SCU Coordinator on 04/25/25 at 2:41pm. Refer to the interview with the Administrator on 04/15/25 at 2:50pm. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 04/16/25 at 11:48am. 2. Review of Resident #9's current FL-2 revealed: -Diagnoses included dementia with agitation, delusional, altered mental status, and psychosis. -She was intermittently disoriented. -The level of care was Special Care Unit (SCU). -There was no order for Resident #9 for self-administration of medications. Observation of a shared bathroom for Residents #8 and #9 on 04/15/24 at 8:41am revealed there was a tube of hydrocortisone, preparation-h, and Neosporin on the residents' bathroom counter. Based on observations, interviews, and record reviews, it was determined Resident #9 was not interviewable.	D 378		

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D 378	Continued From page 37 Refer to the interview with a personal care aide (PCA) on 04/15/25 at 2:11pm. Refer to the interview with a second PCA on 04/15/25 at 2:16pm. Refer to the interview with the medication aide (MA) on 04/15/25 at 2:30pm. Refer to the interview with the SCU Coordinator on 04/25/25 at 2:41pm. Refer to the interview with the Administrator on 04/15/25 at 2:50pm. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 04/16/25 at 11:48am. Interview with a PCA on 04/15/25 at 2:11pm revealed: -Multiple [named] residents wandered into other residents' rooms. The resident's personal items were kept on the shelves in the bathroom. Interview with a second PCA on 04/15/25 at 2:16pm revealed: -Multiple [named] residents wandered into other residents' rooms. The resident's personal items were kept on the shelves in the bathroom. -There were no residents in the SCU who administered their own medications. Interview with the MA on 04/15/25 at 2:30pm revealed: -Creams should be locked on the medication cart. -Creams such as Neosporin and cortisone should be applied by the MA.	D 378		

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D 378	Continued From page 38 Interview with the SCU Coordinator on 04/25/25 at 2:41pm revealed Neosporin and cortisone type creams were kept in the cabinets in resident rooms. Interview with the Administrator on 04/15/25 at 2:50pm revealed: -There were no residents in the SCU who had an order to self-administer medications including creams. -Creams should be kept on the medication cart. Telephone interview with the facility's contracted primary care provider (PCP) on 04/16/25 at 11:48am revealed: -Creams such as Neosporin and cortisone should be out of reach of the residents. -Creams should be locked on the medication cart.	D 378		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided	D 463	D463: Pre-admission screening was created and added to the pre-admission packet. Only the RCD or ED completes assessments, and both parties are informed. (Complete Date 6/2/2025)	

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NAME OF PROVIDER OR SUPPLIER THE OAKS OF ALAMANCE		STREET ADDRESS, CITY, STATE, ZIP CODE 1670 WESTBROOK AVENUE BURLINGTON, NC 27215		
(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 463	Continued From page 39 disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled residents (#2, #3, #5) residing in the Special Care Unit (SCU) had a pre-admission screening for appropriate placement in the SCU. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed as a special care unit (SCU) facility with a capacity of 16 beds. 1. Review of Resident # 2's current FL-2 dated 07/30/25 revealed: -Diagnosis of Alzheimer's, atrial fibrillation, hyperlipidemia, vitamin B12 deficiency and diverticulosis. -She was constantly disoriented. -Her current level of recommended care was memory care. -She had an inappropriate behavior of wandering. -She used a walker to assist with ambulation. Review of Resident #2's SCU resident record revealed no documentation of a SCU pre-admission screening to evaluate the appropriateness of the resident's placement in the SCU. Review of Resident #2's Resident Register revealed she had significant loss and memory	D 463		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER THE OAKS OF ALAMANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 1670 WESTBROOK AVENUE BURLINGTON, NC 27215		
(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 463	Continued From page 40 and must be directed. Refer to the interview with the RCD on 04/16/25 at 2:15pm. Refer to the interview with the Administrator on 04/16/25 at 8:50am and 3:02pm. 2. Review of Resident #3's current FL-2 dated 03/03/25 revealed: -Diagnoses included type 2 diabetes, retention of urine, hypertension, and hyperlipidemia. -He was intermittently disoriented. -He had an inappropriate behavior of wandering. -He was semi-ambulatory with a walker. -The current level of care was Assisted Living (AL) and the recommended level of care was a special care unit (SCU). Review of Resident #3's SCU resident record revealed no documentation of a SCU pre-admission screening to evaluate the appropriateness of the resident's placement in the SCU. Review of Resident #3's care plan dated 02/27/25 revealed: -He required supervision with eating, ambulation and transferring. -He required limited assistance with toileting, bathing, dressing and grooming. Review of Resident #3's after-visit summary dated 03/03/25 revealed: -Resident #1 had a diagnosis of dementia. -Resident #3's dementia was progressing, and he needed placement in a SCU due to wandering. Interview with the Resident Care Director (RCD) on 04/16/25 at 2:15pm revealed Resident #3 had	D 463			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/16/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE OAKS OF ALAMANCE

**1670 WESTBROOK AVENUE
BURLINGTON, NC 27215**

(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 463	Continued From page 41 been wandering and she knew something was going on with the resident. Refer to the interview with the RCD on 04/16/25 at 2:15pm. Refer to the interview with the Administrator on 04/16/25 at 8:50am and 3:02pm. 3. Review of Resident #5's current FL-2 dated 07/30/24 revealed: -Diagnoses included dementia, congestive heart disease, and hypertension. -He was intermittently disoriented. -He was ambulatory. -The level of care was a special care unit (SCU). Review of Resident #5's SCU resident record revealed no documentation of a SCU pre-admission screening to evaluate the appropriateness of the resident's placement in the SCU. Review of Resident #5's care plan dated 03/13/25 revealed he required limited assistance with toileting, bathing, dressing, eating, ambulation, transferring and grooming. Interview with the Resident Care Director (RCD) on 04/16/25 at 2:15pm revealed Resident #5 moved from the community and she did not do his initial assessment. Refer to the interview with the RCD on 04/16/25 at 2:15pm. Refer to the interview with the Administrator on 04/16/25 at 8:50am and 3:02pm. Interview with the RCD on 04/16/25 at 2:15pm	D 463		

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STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001134	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER THE OAKS OF ALAMANCE		STREET ADDRESS, CITY, STATE, ZIP CODE 1670 WESTBROOK AVENUE BURLINGTON, NC 27215		
(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 463	Continued From page 42 revealed: -She and/or the Administrator did an assessment on new admissions to the SCU. -She would ask the resident questions such as the year and date. -She would ask questions the resident should know. -The RCD or Administrator were responsible for completing a pre-screening assessment prior to admission to determine if the resident is appropriate for the SCU. -There was no documentation of the pre-screening assessments in the residents' record. Interview with the Administrator on 04/16/25 at 8:50am and 3:02pm revealed: -He was not aware a pre-screening assessment for the SCU needed to be in the residents' record. -The facility staff did not do a pre-screening form for residents admitted to the SCU. -He and/or the RCD reviewed the resident's medical record to ensure a dementia diagnosis and reviewed the resident's history and physical to make sure the resident's needs matched their paperwork. -There was no documentation to show any type of prescreening. -He and the RCD were responsible for completing a pre-screening assessment of residents prior to their admission to the SCU. -If a resident were coming from another facility, he reviewed the FL2 and completed an assessment to ensure the information on the FL2 matched the recommend level of care. -He expected the pre-screening assessment to be completed prior to admission and documented in the residents' record.	D 463		