

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL063022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/23/2025
NAME OF PROVIDER OR SUPPLIER FOX HOLLOW SENIOR LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 190 FOX HOLLOW PINEHURST, NC 28374		
(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 from 04/22/25 to 04/23/25.	D 000		
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, interviews, and record reviews, the facility failed to ensure the facility was free from hazards as evidenced by unsecured oxygen cylinders stored in a resident's room. The findings are: Observation of room 116 on the Special Care Unit (SCU) on 04/22/25 from 9:11am to 9:13am revealed: -In the corner, by the door, there was a portable oxygen cylinder cart containing one oxygen cylinder. -There was a metal oxygen cylinder storage rack containing 7 oxygen cylinders.	D 079	10A NCAC 13 F .0306(a)(5) Housekeeping and Furniture The community failed to ensure the facility was free from hazards, as evidenced by unsecured oxygen cylinders stored in a resident's room. All residents with oxygen will have task reminders assigned in Point Click Care to assess and ensure the correct storage of oxygen cylinders. The Director of Health and Wellness or designee will assess during daily walkthroughs that oxygen cylinders are stored correctly. Backup racks will be ordered to ensure proper equipment is in the community for the storage of cylinders. Team members to be educated on the Five Star Oxygen Storage Policy during the monthly clinical team meeting on 5/29/25. Completion Date: 5/31/25	

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

Machella N. Brack

TITLE

Executive Director

(X6) DATE

6-4-25

STATE FORM

6899

VMXA11

If continuation sheet 1 of 32

Reviewed and Acknowledged 06/06/25 *Anna A. Kopf*

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D 079	Continued From page 1 -There were 2 oxygen cylinders on the floor in front of the storage rack. -The 2 oxygen cylinders on the floor had a green band around the valve post opening. Interview with a medication aide (MA) on 04/22/25 at 9:50am revealed: -The resident in room 116 used oxygen as needed; she was not on continuous oxygen. -Residents who were on oxygen stored their oxygen cylinders in their rooms. -The oxygen cylinders were stored in a rack or crate. -The green band on the valve post indicated the oxygen cylinder was full. -The 2 oxygen cylinders in room 116 were on the floor because there was no other place to store them. -She was unsure whether oxygen cylinders could be stored on the floor; she had been told the tanks could not be locked in a closet. Interview with the Special Care Unit Coordinator (SCC) on 04/22/25 at 9:58am revealed: -Residents who used oxygen stored their oxygen cylinders in their room. -Oxygen cylinders should be stored in a rack. -Oxygen cylinders should not be stored on the floor, but she was unsure why. -She was responsible for completing room checks daily on the SCU to check for hazards. -She had not completed the room checks on SCU yet this morning, 04/22/25. -She thought the oxygen company delivered the wrong size of oxygen cylinder rack and there was not anywhere else to store the resident's oxygen cylinders. Interview with the Resident Care Coordinator (RCC) on 04/22/25 at 10:05am revealed:	D 079			

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D 079	Continued From page 2 -Residents who were on oxygen stored their oxygen cylinders in their rooms. -Oxygen cylinders should be stored in a rack. -She was unsure why the oxygen cylinders were on the floor this morning, 04/22/25. -Full, unsecured oxygen cylinders could explode if they fell over, so the oxygen cylinders should be stored securely in a rack. -The SCU staff and the SCC should be checking the resident rooms for hazards daily. -She was unsure if the residents' rooms on the SCU were checked this morning, 04/22/25. -She checked the SCU residents' rooms monthly for any hazards. Interview with the Administrator on 04/23/25 at 4:35pm revealed: -Residents who used oxygen stored their oxygen cylinders in their rooms. -Oxygen cylinders should be stored in a storage rack. -Oxygen cylinders should not be stored on the floor. -If there was not a rack in the resident's room for oxygen cylinders, the staff should contact the medical equipment company and request a rack for storage. -Full, unsecured oxygen cylinders were dangerous and a safety concern to the residents because the tank could explode if overturned.	D 079		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion	D 263		

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D 263	Continued From page 3 of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled residents (#1, #3) had a care plan completed and signed by the residents' primary care provider (PCP). The findings are: 1. Review of Resident #3's current FL2 dated 02/25/25 revealed diagnoses included unspecified dementia, Alzheimer's disease, major depressive disorder, and age-related osteoarthritis. Review of Resident #3's Resident Register revealed an admission date of 01/29/24. Review of Resident #3's care plan dated 01/31/24 revealed: -Resident #3 resided in the Special Care Unit (SCU). -Resident #3 required supervision with ambulation, bathing, and grooming. -Resident #3 required verbal cues/reminders with dressing and meals. -Resident #3 was independent with toileting. -The care plan was not signed by the assessor and was dated 01/31/24. -The care plan was signed by Resident #3's primary care provider (PCP) on 02/01/24. Review of Resident #3's care plan dated 12/17/24	D 263	10A NCAC 13F .0802 (e) Resident Care Plan The community failed to produce signed care plans from two out of five sampled residents' care plans. The Director of Health of Wellness is currently conducting an audit of all care plans to ensure a signed copy is in the resident's chart. DHW or designee moving forward will keep an ongoing log of all care plans that are completed and faxed/ mailed/ or transported directly to MD offices to ensure return of signed copy within 15 days. DHW provided education to the transportation team as it relates to the timeframe that paperwork needs to be delivered and returned to the community. New electronic medical record system put in place in the community as of 5/5/2025 will also prompt DHW or designee will review of evaluation due for the week and the month on a weekly basis and will update as completed. The care plan audit for all residents will be completed by the end of the month. Completion date: 5/31/25		

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D 263	Continued From page 4 revealed: -Resident #3 resided on the Special Care Unit (SCU). -Resident #3 required supervision with ambulation, bathing, and grooming. -Resident #3 required verbal cues/reminders with dressing and meals. -Resident #3 was independent with toileting.-The care plan was electronically signed by the assessor on 12/17/24. -The care plan was not signed by Resident #3's PCP. Review of Resident #3's record revealed there were no other care plans available for review. Interview with a medication aide (MA) on 04/23/25 at 2:50pm revealed: -Resident #3 required assistance of 1 staff member for bathing. -Resident #3 refused to bathe at times. -Resident #3 required supervision with grooming and dressing. -Resident #3 was independent with ambulation, transfers, and eating. Interview with the Special Care Unit Coordinator (SCC) on 04/23/25 at 4:22pm revealed: -The Health and Wellness Director was responsible for completing care plans for residents on the SCU. -She was not responsible for completing the care plans for SCU residents. -She reported any changes in residents' condition to the HWD. Interview with the HWD on 04/23/25 at 3:42pm revealed: -She started working at the facility as the HWD on 01/20/25.	D 263			

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D 263	Continued From page 5 -She was responsible for completing the residents' care plans. -Care plans were updated every 3 months for residents on the SCU. -She was aware the residents' care plans should be signed by the PCP within 15 days. -She was unsure why Resident #3's care plan was not signed because it was completed before she started working at the facility. -She was in the process of auditing to determine which residents needed an updated care plan. -She was in the process of developing a process to track items that required a PCP's signature. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. Attempted telephone interview with Resident #3's PCP on 04/23/25 at 3:01pm was unsuccessful. Refer to interview with the Administrator on 04/23/25 at 4:35pm. 2. Review of Resident #1's current FL-2 dated 03/25/25 revealed diagnoses included closed burst fracture of lumbar vertebra, lumbar compression fracture, cervical radiculopathy, type 2 diabetes mellitus, moderate late onset Alzheimer's dementia, osteoporosis, and arthritis. Review of Resident #1's Resident Register revealed an admission date of 12/31/24. Review of Resident #1's care plan dated 02/05/25 revealed: -Resident #1 resided on the Special Care Unit (SCU). -Reason for the evaluation was significant change.	D 263		

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D 263	Continued From page 6 -Resident #1 required physical assistance with ambulation, transfers, and bathing. -Resident #1 required supervision with dressing. -Resident #1 required continuous supervision with toileting, -Resident #1 required verbal cues to attend meals. -The care plan was electronically signed by the assessor on 02/05/25. -The care plan was not signed by Resident #1's primary care provider (PCP). Review of Resident #1's record revealed there were no other care plans available for review. Interview with a medication aide (MA) on 04/23/25 at 2:50pm revealed: -Resident #1 required 2 staff members for transfers. -Resident #1 used a wheelchair for mobility and could propel himself until a few days ago. -Resident #1 required assistance with bathing, dressing, grooming, and toileting. -Resident #1 was able to feed himself until this week. -The facility staff was now feeding Resident #1. -Resident #1 received hospice services and had a recent change in condition. Interview with the Special Care Unit Coordinator (SCC) on 04/23/25 at 4:22pm revealed: -The Health and Wellness Director was responsible for completing care plans for residents on the SCU. -She was not responsible for completing care plans for SCU residents. -She reported any changes in residents' condition to the HWD. -Resident #1 received hospice services and had a change in condition this week.	D 263			

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D 263	Continued From page 7 Interview with the HWD on 04/23/25 at 3:42pm revealed: -She started working at the facility as the HWD on 01/20/25. -She was responsible for completing the residents' care plans. -Care plans were updated every 3 months for residents on the SCU. -She was aware the residents' care plans should be signed by the PCP within 15 days. -She completed Resident #1's care plan on 02/05/25. -She was not aware Resident #1's care plan was not signed by his PCP until 04/22/25. -Resident #1's PCP signed the care plan on 04/22/25. -She was in the process of auditing to determine which residents needed an updated care plan. -She was in the process of developing a process to track items that required a PCP's signature. -She was still in the process of training for her position during the time Resident #1's care plan was completed, so it was an oversight that Resident #1's care plan was not signed. -Some items were faxed to the PCP, but the transportation coordinator was now taking some items to the PCP's offices for signature. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable. Attempted telephone interview with Resident #1's PCP on 04/23/25 at 4:11pm was unsuccessful. Refer to interview with the Administrator on 04/23/25 at 4:35pm. Interview with the Administrator on 04/23/25 at	D 263		

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D 263	Continued From page 8 4:35pm revealed: -The Health and Wellness Director (HWD) or designee was responsible for completing the residents' care plans. -The facility had some transitions with staff members and the HWD started at the facility in January 2025. -Care plans are completed within 30 days of admission, annually, or in the event of a significant change. -The HWD sent the care plans to the residents' primary care provider (PCP) for signature when completed. -The care plans should be signed by the PCP within 2 weeks. -She was not aware some of the residents' care plans were not signed by the PCP. -The care plans were usually faxed to the PCPs for signature, but the facility's transportation coordinator had started taking some items for signature. -The HWD was responsible for following up with the residents' PCPs to ensure the care plans were signed within 2 weeks of completion.	D 263		
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: Based on observations, interviews, and record reviews, the facility failed to ensure health care follow up to meet the health care needs for 1 of 5 sampled residents (#4).	D 273		

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D 273	Continued From page 9 The findings are: Review of Resident #4's current FL2 dated 12/17/24 revealed diagnoses included hypertension, sinus bradycardia, benign prostatic hyperplasia, testosterone deficiency, and urinary frequency. Review of Resident #4's accident/incident (A/I) report dated 12/13/24 at 2:01pm revealed: -The resident fell to his knees in the elevator. -The resident told staff that he lost his balance while getting on the elevator. -No injuries were observed at the time of incident. -The primary care provider (PCP) and the power of attorney (POA) were notified. -A physical therapy (PT) order was requested. Review of Resident #4's progress notes revealed: -On 12/13/24 at 3:00pm, a medication aide (MA) documented that Resident #4 "fell as he was getting on the elevator and got up himself". -The MA asked the PCP for a PT order. Review of Resident #4's PCP progress note dated 12/17/24 revealed: -Resident #4 stated, "he fell in his room today because he tripped over his cane and would like a rollator because he does have difficulty with falling". -Resident #4 was observed walking in the hall and had a forward leaning fast gait. -The treatment plan was to refer the resident for PT/occupational therapy (OT), and a rollator with seat. -The treatment plan stated, "to restore function PT/OT services as ordered to evaluate and treat the patient's gait abnormalities, fall, and hypertension". -The PCP documented that, "In my judgment	D 273	10A NCAC 13F .0902 (b) Health Care The community failed to ensure health care follow-up to meet the health care needs for one of five sampled residents. The community failed to follow up on a physical therapy consult for the resident post-fall. The Director of Health and Wellness now receives updates from Life Source healthcare management services of all resident referrals placed via visiting NP for the community. In addition, the transportation team has been educated to return all resident appointment folders directly to the DHW or designee for processing orders after appointments to ensure follow-up is provided as directed. DHW or designee will hold AM and PM clinical stand-up meetings with the clinical team and review care needs and what follow-up is needed. Medication techs have been instructed to leave a copy of all new orders obtained via fax in the DHW mailbox in the office area to ensure orders are entered correctly and referrals are arranged. Lab orders will be added to Point Click Care to be completed on designated days with any preparatory instructions provided with prompting to staff through the EMR system.	

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D 273	Continued From page 10 there is a reasonable expectation that the patient can and will demonstrate improved function as a result of this intervention, over the next two months". Interview with a MA on 04/23/25 at 2:45pm revealed that the PCP gave an order for someone to come out and administer a PT evaluation, but she could not recall what agency the referral was made to do the evaluation. Interview with the Health and Wellness Director (HWD) on 04/23/25 at 3:25pm revealed: -She was not aware that no one had followed up on the PT referral evaluation for Resident #4. -The PCP made arrangements with an outside agency to administer a PT evaluation for Resident #4. -The facility did not get notification that the appointment from the referral to administer the PT evaluation was or was not made for Resident #4. Interview with the Administrator on 04/23/25 at 3:45pm and 4:15pm revealed: -She was not made aware of a PT referral for Resident #4. -The resident should go through PT inhouse first and if there is an issue with insurance then a designee in the clinical department should have reached out to the PCP regarding the concern. -She believed someone came out to do the PT referral, but she could not say what agency came out or when. -A designee (MA or Administrator) overseeing the clinical department was responsible for overseeing the PT referral was followed through. -It appeared the facility did not reach out to the outside home health agency.	D 273			

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D 273	Continued From page 11 Interview with Resident #4's PCP assistant on 04/23/25 at 4:00pm revealed: -A PT order was made for the resident on 12/17/24. -The agency reached out to her requesting PCP to clarify the order. -The facility reached out to her for an update on 04/23/25 regarding Resident #4's PT referral. Interview with Resident #4's PCP on 04/23/25 at 4:20pm revealed: -She ordered the PT evaluation as an intervention to reduce falls. -Some facilities made their own referrals and at other facilities she sent in the referral for PT. -The facility was responsible for ensuring the follow up was complete. Attempted telephone interview with Resident #4's family member on 04/23/24 at 3:15pm was unsuccessful.	D 273		
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 interviews and record reviews, the facility failed to implement orders for 1 of 5 sampled residents (#3) related to an order for blood work for a resident's vitamin D level.	D 276	10A NCAC 13F .0902 (c) (3-4) Health Care The community was unable to produce lab work for resident 3 in the sample that was recommended on a quarterly pharmacy review. The community was able to obtain a copy of the lab work after the survey team had exited, and it was completed.	

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D 276	Continued From page 12 The findings are: Review of Resident #3's current FL2 dated 02/25/25 revealed diagnoses included unspecified dementia, Alzheimer's disease, major depressive disorder, and age-related osteoarthritis. Review of the facility's contracted pharmacy's medication review dated 01/23/25 revealed: -There was a recommendation for Resident #3 to have a vitamin D level drawn on the next convenient lab day. -The recommendation was accepted and signed by Resident #3's primary care provider (PCP) on 03/11/25. Review of Resident #3's record revealed: -Resident #3's last vitamin D level was drawn on 10/30/24. -There were no other vitamin D levels available for review. Interview with a medication aide (MA) on 04/23/25 at 2:29pm revealed: -If she received a signed pharmacy recommendation from the facility's fax machine, she usually faxed the recommendation to the pharmacy. -If the recommendation had a medication order, she changed the order on the resident's medication administration record (MAR). -If the recommendation was for lab work, the Health and Wellness Director (HWD) handled scheduling the lab work. -She gave a copy of the signed pharmacy recommendations to the HWD. Interview with the HWD on 04/23/25 at 3:42pm	D 276	The community failed to ensure health care follow-up to meet the health care needs for one of five sampled residents. The Director of Health and Wellness now receives updates from Life Source healthcare management services of all resident referrals placed via visiting NP for the community. In addition, the transportation team has been educated to return all resident appointment folders directly to the DHW or designee for processing after appointments to ensure follow-up is provided as directed. DHW or designee will hold AM and PM clinical stand-up meetings with the clinical team and review care needs and what follow-up is needed. Medication techs have been instructed to leave a copy of all new orders obtained via fax in the DHW mailbox in the office area to ensure orders are entered correctly and referrals are arranged. Lab orders will be added into Point Click Care to be completed on designated days with any preparatory instructions provided with prompting to staff through the EMR system. Completion Date: May 31st, 2025	

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NAME OF PROVIDER OR SUPPLIER FOX HOLLOW SENIOR LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 190 FOX HOLLOW PINEHURST, NC 28374		
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D 276	Continued From page 13 revealed: -A pharmacist from the facility's contracted pharmacy completed quarterly medication reviews. -When the pharmacist completed the review, the review was sent via email to her the following day. -She was responsible for sending the pharmacy recommendations to the residents' primary care providers (PCPs). -There was not a specific time frame to send the recommendations to PCPs, but she sent them as soon as possible. -She did not recall seeing a pharmacy recommendation for Resident #3 dated 01/23/25. -Resident #3 had not had a vitamin D level drawn since 10/30/24. -The accepted recommendation for Resident #3 to have a vitamin D level drawn must have been filed and overlooked. -Resident #3 should have been scheduled for a vitamin D level to be drawn by the lab when the recommendation was signed by the PCP. Interview with the Administrator on 04/23/25 at 4:35pm revealed: -A pharmacist from the facility's contracted pharmacy completed medication reviews quarterly. -When the medication review was completed, the pharmacist sent the recommendations via email to her and the HWD. -She was unsure why Resident #3's vitamin D level was not drawn after the recommendation was reviewed by the PCP, unless the order was overlooked. -The facility had a contract with a lab service that came to the facility, so labs could be drawn in a timely manner. -MAs should make a copy of any pharmacy recommendations received for the HWD, so the	D 276		

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D 276	Continued From page 14 HWD could track them and ensure the recommendations were completed. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. Attempted telephone interview with Resident #3's PCP on 04/23/25 at 3:01pm was unsuccessful.	D 276		
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 2 of 4 residents (#1, #6) observed during the medication pass including a medication used to treat pain (#1), a medication used to treat or prevent vitamin and mineral deficiencies (#1), a medication used to treat allergy symptoms (#1), and a medication used to treat hypothyroidism (#6); and for 1 of 5 sampled residents (#1) for record review for a medication used to treat depression or weight loss. The findings are:	D 358	10A NCAC 13F .1004 (a) Medication Administration The community failed to administer medications as ordered for two of four residents during an observed medication pass. The community was unable to prepare and administer medication and treatments in accordance with orders from a licensed prescribing practitioner and the facility's policies and procedures. Levothyroxine medication was not administered in enough time before other medications and breakfast. Medication administration time for all residents taking levothyroxine in AM has been changed to 6 am. The third shift will now administer this medication between 5 am and 7 am. All other AM medications to be administered by AM staff on shift from 7 am to 3 pm. The Director of Health and Wellness or designee will perform weekly medication administration audits, alternating staff to review each med aid quarterly and assess for re-education needs. Weekly visits from RN to assess orders and oversee ongoing training needs for medication aids will continue. Completion Date: May 31st, 2025	

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D 358	Continued From page 15 Review of the facility's medication management policy dated 06/09/23 revealed all medications provided to a resident by medication administration procedures are ordered, in writing, by the resident's physician/healthcare provider. The medication error rate was 14% as evidenced by 4 errors out of 27 opportunities during the 8:00am medication passes on 04/22/25 and 04/23/25. 1. Review of Resident #1's current FL-2 dated 03/25/25 revealed diagnoses included closed burst fracture of lumbar vertebra, lumbar compression fracture, cervical radiculopathy, type 2 diabetes mellitus, moderate late-onset Alzheimer's dementia, osteoporosis, and arthritis. a. Review of Resident #1's current FL2 dated 03/25/25 revealed: -There was an order for Calcium Carbonate 600mg+D take 1 tablet in the morning and 1 tablet before bedtime (Calcium Carbonate 600mg+D is a vitamin and mineral supplement used to prevent or treat vitamin and mineral deficiencies). -There was no order for Resident #1's medications to be crushed. Observation of the 8:00am medication pass on the Special Care Unit (SCU) on 04/22/25 from 9:13am to 9:48am revealed: -The medication aide (MA) placed 1 Calcium Carbonate 600mg+D tablet in a plastic cup and emptied the tablet into a plastic pouch. -The MA placed the plastic pouch into the pill crushing device and crushed the tablet at 9:24am. -The MA emptied the contents of the pouch into a plastic medication cup.	D 358		

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D 358	Continued From page 16 -The MA prepared Resident #1's remaining oral medication, mixed the medications with yogurt, and administered the medications at 9:41am. Review of Resident #1's April 2025 medication administration record (MAR) revealed: -There was an entry for Calcium Carbonate 600mg+D scheduled for 8:00am and 8:00pm. -Calcium Carbonate 600mg+D was documented as administered daily at 8:00am from 04/01/25 to 04/22/25, and at 8:00pm from 04/01/25 to 04/20/25. -Calcium Carbonate 600mg+D was documented as refused at 8:00pm on 04/21/25. -There was no entry to crush medications. b. Review of Resident #1's current FL2 dated 03/25/25 revealed: -There was an order for Acetaminophen 500mg take 2 tablets three times daily (Acetaminophen is a medication used to treat pain). -There was no order for Resident #1's medications to be crushed. Observation of the 8:00am medication pass on the SCU on 04/22/25 from 9:21am to 9:48am revealed: -The MA crushed one of Resident #1's oral medications and emptied the contents into a plastic medication cup. -The MA donned gloves and removed 2 Acetaminophen Rapid Release 500mg gelcaps from a medication bottle. -The MA removed the outer gelcap coating from the 2 Acetaminophen Rapid Release 500mg tablets and placed the contents of the gelcaps into a plastic medication cup. -The MA emptied the contents of the 2 gelcaps from the cup and into a plastic pouch and crushed the contents of the gelcaps at 9:25am.	D 358		

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D 358	Continued From page 17 -The MA emptied the contents of the plastic pouch into a plastic medication cup with Resident #1's other oral medication, mixed the medications with yogurt, and administered the medications at 9:41am. Review of Resident #1's April 2025 medication administration record (MAR) revealed: -There was an entry for Acetaminophen 500mg 2 tablets three times daily scheduled for 8:00am, 4:00pm, and 10:00pm. -Acetaminophen 500mg 2 tablets was documented as administered daily at 8:00am from 04/01/25 to 04/22/25, at 4:00pm from 04/01/25 to 04/21/25, and 10:00pm from 04/01/25 to 04/20/25. -Acetaminophen 500mg 2 tablets was documented as refused at 10:00pm on 04/21/25. -There was no entry to crush medications. c. Review of Resident #1's current FL2 dated 03/25/25 revealed there was an order for Ipratropium Bromide 0.06% Nasal Spray administer 2 sprays into each nostril three times daily (Ipratropium Bromide Nasal Spray is a medication used to treat allergy symptoms). Observation of the 8:00am medication pass on the SCU on 04/22/25 from 9:21am to 9:48am revealed: -The MA removed Ipratropium Bromide 0.03% Nasal Spray from the medication cart. -The MA donned gloves and entered Resident #1's room at 9:46am. -The MA assisted Resident #1 with blowing his nose into a tissue at 9:47am. -The MA administered 2 sprays of Ipratropium Bromide 0.03% Nasal Spray in each one of Resident #1's nostrils at 9:48am.	D 358			

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D 358	Continued From page 18 Review of Resident #1's April 2025 medication administration record (MAR) revealed: -There was an entry for Ipratropium Bromide 0.06% Nasal Spray 2 sprays into each nostril three times daily scheduled for 8:00am, 2:00pm, and 8:00pm. -Ipratropium Bromide 0.06% Nasal Spray was documented as administered at 8:00am on 21 of 22 days, at 2:00pm on 16 of 21 days, and at 8:00pm on 20 of 21 days. -Ipratropium Bromide 0.06% Nasal Spray was documented as refused by Resident #1 on 04/21/25 at 8:00am, at 2:00pm on 04/15/25, 04/16/25, 04/17/25, 04/18/25, and 04/21/25, and at 8:00pm on 04/21/25. Interview with the MA on 04/22/25 at 2:30pm revealed: -She followed the instructions on the residents' MAR when she administered medications to residents. -If a resident had an order for their medications to be crushed, there were instructions on the resident's MAR. -Resident #1 did not have an order to crush his medications. -She crushed Resident #1's medications this morning because he was having difficulty taking his medications and would not take them whole. -She was aware that the resident's primary care provider (PCP) must give an order to crush medications. -She did not notice Resident #1's Ipratropium Bromide nasal spray on hand was not the dose on the MAR. -The residents' medication labels should match the resident's MARs. -If the resident's medication label and MAR did not match, the medication order should be clarified with the resident's PCP.	D 358		

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D 358	Continued From page 19 Interview with the Special Care Unit Coordinator (SCC) on 04/23/25 at 4:22pm revealed: -MAs should follow the instructions on the residents' MARs when administering medications. -She was not informed Resident #1 was having difficulty taking medications. -An order from the PCP was required to crush any medications. -If MAs were administering medications and the medication on the medication cart did not match the resident's MAR, the MA should not administer the medication. -MAs should contact the resident's PCP if clarification was needed for medication orders. Interview with the Health and Wellness Director (HWD) on 04/23/25 at 3:42pm revealed: -MAs should follow the instructions on residents' MARs when administering medications. -If a resident had orders for their medications to be crushed, the order would be on the resident's MAR. -MAs must have an order to crush residents' medications. -It was important to have an order because some medications cannot be crushed. -She was not aware Resident #1 was having difficulty taking his medications. -If a resident was having difficulty taking their medications, the MA should report to the SCC or HWD. -If a medication was on the medication cart and did not match the resident's MAR, that medication should be removed from the medication cart and not administered. -If the medication on the cart did not match the medication order on the MAR, the MA should clarify the order with the resident's PCP.	D 358		

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D 358	Continued From page 20 Interview with the Administrator on 04/23/25 at 4:35pm revealed: -MAs should administer medications according to the instructions on the residents' MARs. -If a resident was having difficulty taking the medications, the MA should notify the HWD or the resident's PCP. -MAs must have an order to crush medications because some medications could not be crushed. -When MAs administered medications, if the medication on the medication cart did not match the order on the MAR, the MA should not administer the medication. -MAs should clarification from the resident's PCP if there are questions about medications. Telephone interview with a pharmacist from Resident #1's contracted pharmacy on 04/23/25 at 3:03pm revealed: -She was unsure what the facility's policy was for crushed medications. -Ipratropium Bromide Nasal Spray was used to treat allergy symptoms. -The pharmacy last filled Resident #1's Ipratropium Bromide 0.03% Nasal Spray on 03/19/25. -Prior to the order received on 03/19/25, the pharmacy had filled Ipratropium Bromide 0.06% nasal spray for Resident #1 since October 2024. -If Resident #1 did not receive the correct dose of the Ipratropium Bromide nasal spray, it could lead to a worsening of his symptoms. Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/23/25 at 4:12pm revealed: -MAs should follow the instructions on the residents' MARs when administering medications. -There should be an order from the resident's PCP to crush medications.	D 358		

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D 358	Continued From page 21 -Certain medication should not be crushed because crushing the medication could change the way the medication was absorbed in the body. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable. Attempted telephone interview with Resident #1's PCP on 04/23/25 at 4:11pm was not successful. 2. Review of Resident #6's current FL2 dated 12/10/25 revealed diagnoses included chronic obstructive pulmonary disease, essential hypertension, and major depressive disorder. Review of Resident #6's signed primary care provider's (PCP) orders dated 01/24/25 revealed there was an order for Levothyroxine 25mcg take 1 tablet in the morning 30 minutes before eating (Levothyroxine is a medication used to treat an underactive thyroid gland). Observation of the assisted living (AL) 8:00am medication pass on 04/23/25 from 7:48am to 8:30am revealed: -The medication aide (MA) started preparing Resident #6's oral medications at 7:49am. -The MA prepared Resident #6's medications, including Levothyroxine 25mcg. -The MA administered Resident #6's oral medications at 7:56am. -Resident #6 completed taking his oral medications at 7:57am. -Resident #6 left the 2nd floor of the facility and went to the dining room at 8:01am. Observation of the AL breakfast meal on 04/23/25 revealed Resident #6 received his breakfast plate	D 358		

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D 358	Continued From page 22 at 8:10am and immediately started eating his meal. Review of Resident #6's April 2025 medication administration record (MAR) revealed: -There was an entry for Levothyroxine 25mcg take 1 tablet in the morning 30 minutes before eating scheduled for 7:30am. -Levothyroxine 25mcg was documented as administered at 7:30am from 04/01/25 to 04/23/25. Interview with Resident #6 on 04/23/25 at 8:35am revealed: -He was unsure the names of his medications. -He usually took all his morning medications at the same time. Interview with the MA on 04/23/25 at 2:29pm revealed: -She followed the instructions on the residents' MARs when she administered medications to residents. -She was unsure if she noticed Resident #6's MAR instructions were to administer Levothyroxine 25mcg 30 minutes before eating. -She usually administered all of Resident #6's morning medications at the same time, around 8:00am. -She did not usually administer Resident #6's Levothyroxine before she administered his other medications. -Medications should be administered at the time scheduled on the residents' MARs. Interview with the Health and Wellness Director (HWD) on 04/23/25 at 3:42pm revealed: -MAs should administer medications according to the instructions on the residents' MARs. -Any medications scheduled before a meal	D 358			

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D 358	Continued From page 23 should be administered at the time on the residents' MAR. -Resident #6's Levothyroxine should be administered before his other medications. -Levothyroxine may not be properly absorbed if the medication was not taken on an empty stomach. -The MA should have checked Resident #6's MAR and administered Levothyroxine at the time scheduled on the MAR. Interview with the Administrator on 04/23/25 at 4:35pm revealed: -MAs should administer residents' medications at the time scheduled on the residents' MAR. -If MAs have questions about the orders on the residents' MARs, they should ask the HWD. -If a medication was scheduled before a meal, the MA should administer the medication at the time specified on the resident's MAR. -The MA should have instructed Resident #6 to wait 30 minutes before going to the dining room for his meal. Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/23/25 at 4:12pm revealed: -Resident #6's Levothyroxine was scheduled to be administered 30 minutes before a meal. -The absorption of Levothyroxine was decreased when administered too close to meal. -Resident #6's thyroid levels could potentially be impacted if the medication was administered with food on a regular basis. Attempted telephone interview with Resident #6's PCP on 04/23/25 at 3:01pm was unsuccessful. 3. Review of Resident #1's current FL-2 dated 03/25/25 revealed:	D 358		

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NAME OF PROVIDER OR SUPPLIER FOX HOLLOW SENIOR LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 190 FOX HOLLOW PINEHURST, NC 28374		
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D 358	Continued From page 24 -Diagnoses included closed burst fracture of lumbar vertebra, lumbar compression fracture, cervical radiculopathy, type 2 diabetes mellitus, moderate late onset Alzheimer's dementia, osteoporosis, and arthritis. -There was an order for Mirtazapine 7.5mg take 1 tablet nightly (Mirtazapine is a medication used to treat depression, insomnia, and loss of appetite). Review of Resident #1's primary care provider's (PCP) visit summary dated 04/17/25 revealed Resident #1's current medication list included Mirtazapine 7.5mg 1 tablet nightly. Review of Resident #1's March 2025 medication administration record (MAR) revealed: -There was an entry for Mirtazapine 7.5mg 1 tablet at bedtime scheduled for 8:00pm. -Mirtazapine 7.5mg was documented as administered at 8:00pm from 03/01/25 to 03/16/25, 03/19/25, 03/21/25, 03/22/25, and 03/25/25. -Mirtazapine 7.5mg was documented as refused at 8:00pm on 03/17/25 and 03/18/25. -There was no documentation of Mirtazapine 7.5mg being administered on 03/20/25, 03/23/25, 03/24/25, 03/26/25, 03/27/25, 03/28/25, 03/29/25, 03/30/25, and 03/31/25. Review of Resident #1's April 2025 MAR revealed there was no entry for Mirtazapine 7.5mg 1 tablet nightly. Observation of Resident #1's medications on hand on 04/22/25 at 2:49pm revealed: -Resident #1 had a unit dose card of Mirtazapine 7.5mg filled 03/19/25 for a quantity of 30 tablets. -There were 19 tablets of Mirtazapine 7.5mg remaining.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL063022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/23/2025
NAME OF PROVIDER OR SUPPLIER FOX HOLLOW SENIOR LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 190 FOX HOLLOW PINEHURST, NC 28374		
(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 25 Interview with a medication aide (MA) on 04/22/25 at 2:50pm revealed: -Resident #1 was in the hospital in March 2024 and had some medication orders changed. -When medication orders were received, the MA who received the order was responsible for sending the order to the pharmacy and transcribing the order on the resident's MAR. -The residents' MARs were reviewed monthly using a three check system. -First shift MAs completed the first check of the MARs, second shift MAs completed the second check of the MARs, and the Health and Wellness Director (HWD) completed a third check of the MARs. -She was unsure if Resident #1's April 2025 MAR was checked three times. -She was unsure if Resident #1 was still taking Mirtazapine 7.5mg because she did not work on second shift and the medication was scheduled for bedtime. -Resident #1 received hospice services and had some recent medication changes, so she was unsure why Mirtazapine was not on his April 2025 MAR. Interview with the Special Care Unit Coordinator (SCC) on 04/22/25 at 4:22pm revealed: -Resident #1 had some recent medication changes because he was receiving hospice services. -The residents' MARs were checked monthly by 2 MAs and the HWD. -She was not responsible for the monthly MAR checks. -She was unsure if Resident #1 was currently taking Mirtazapine. -She was unsure why Resident #1's Mirtazapine was not on his April 2025 MAR.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL063022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/23/2025
NAME OF PROVIDER OR SUPPLIER FOX HOLLOW SENIOR LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 190 FOX HOLLOW PINEHURST, NC 28374		
(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 Interview with the HWD on 04/22/25 at 3:42pm revealed: -The residents' MARs were checked each month using a three check system. -Two MAs completed the first and second checks of the residents' MARs, then the third check was completed by the HWD or the Administrator. -She was unsure why Resident #1's Mirtazapine 7.5mg order was not on his MAR. -She was unsure if Resident #1 had been receiving Mirtazapine 7.5mg each night. -She was unsure if Resident #1's April MAR was checked three times. -Resident #1's Mirtazapine 7.5mg order must have been overlooked. Interview with the Administrator on 04/22/25 at 4:35pm revealed: -MAs were responsible for ensuring medication orders were transcribed on the residents' MARs. -The HWD audited the residents' medication orders to ensure the orders were accurate on the residents' MARs. -The residents' MARs were checked monthly using a three check system. -Two MAs checked the residents' monthly MARs and a third check was completed by the HWD. -If MAs noticed an order was not on a residents' MAR, the MA should check the residents' medication orders to verify if the order was still current. -The MAs should report any issues with the MARs to the HWD or check with the resident's PCP if there were questions about a medication order. -She was unsure if Resident #1's April 2025 was checked three times if the Mirtazapine order was not on Resident #1's MAR. -The order for Resident #1's Mirtazapine 7.5mg must have been overlooked.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL063022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/23/2025
NAME OF PROVIDER OR SUPPLIER FOX HOLLOW SENIOR LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 190 FOX HOLLOW PINEHURST, NC 28374		
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D 358	Continued From page 27 Telephone interview with a pharmacist at Resident #1's contracted pharmacy on 04/22/25 at 3:03pm revealed: -The pharmacy last filled Resident #1's Mirtazapine 7.5mg on 03/19/25 for 30 tablets. -The pharmacy had not received any refill requests for Resident #1's Mirtazapine 7.5mg in April 2025. -Mirtazapine was prescribed for mood or insomnia and was sometimes prescribed to help stimulate appetite. -If Resident #1 did not receive Mirtazapine 7.5mg as prescribed, he could have a worsening of the condition for which the medication was prescribed. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable. Attempted telephone interview with Resident #1's PCP on 04/23/25 at 4:11pm was unsuccessful.	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 administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and	D 367	10A NCAC 13F .1004 (j) Medication Administration The community failed to prepare and administer medication and treatments per orders by a licensed prescribing practitioner and the facility's policy and procedure. One of five residents did not receive a prescribed medication because it was not being transcribed on the Medication Administration Record. Weekly visits from RN to assess orders and oversee ongoing training needs for medication aids will continue. All orders will be printed on the first of June and sent to the signing physician to confirm all current orders. Orders will be sent to each resident's provider monthly for the next three months and then every six months thereafter. Orders will be reviewed by the Director of Health Wellness or designee weekly to ensure that residents are administering the medications as prescribed. Completion Date: June 2nd, 2025		

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NAME OF PROVIDER OR SUPPLIER FOX HOLLOW SENIOR LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 190 FOX HOLLOW PINEHURST, NC 28374		
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D 367	Continued From page 28 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 interviews and record reviews, the facility failed to ensure medication administration records were accurate for 1 of 5 sampled residents (#1) including a medication used to treat depression or weight loss. The findings are: Review of Resident #1's current FL-2 dated 03/25/25 revealed: -Diagnoses included closed burst fracture of lumbar vertebra, lumbar compression fracture, cervical radiculopathy, type 2 diabetes mellitus, moderate late onset Alzheimer's dementia, osteoporosis, and arthritis. -There was an order for Mirtazapine 7.5mg take 1 tablet nightly (Mirtazapine is a medication used to treat depression, insomnia, and loss of appetite). Review of Resident #1's March 2025 medication administration record (MAR) revealed: -There was an entry for Mirtazapine 7.5mg 1 tablet at bedtime scheduled for 8:00pm. -Mirtazapine 7.5mg was documented as administered at 8:00pm from 03/01/25 to 03/16/25, 03/19/25, 03/21/25, 03/22/25, and	D 367		

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D 367	Continued From page 29 03/25/25. -Mirtazapine 7.5mg was documented as refused at 8:00pm on 03/17/25 and 03/18/25. -There was no documentation of Mirtazapine 7.5mg being administered on 03/20/25, 03/23/25, 03/24/25, 03/26/25, 03/27/25, 03/28/25, 03/29/25, 03/30/25, and 03/31/25. Review of Resident #1's April 2025 MAR revealed there was no entry for Mirtazapine 7.5mg 1 tablet nightly. Observation of Resident #1's medications on hand on 04/22/25 at 2:49pm revealed: -Resident #1 had a unit dose card of Mirtazapine 7.5mg filled 03/19/25 for a quantity of 30 tablets. -There were 19 tablets of Mirtazapine 7.5mg remaining. Interview with a medication aide (MA) on 04/22/25 at 2:50pm revealed: -Resident #1 was in the hospital in March 2024 and had some medication orders changed. -When medication orders were received, the MA who received the order was responsible for sending the order to the pharmacy and transcribing the order on the resident's MAR. -The residents' MARs were reviewed monthly using a three check system. -First shift MAs completed the first check of the MARs, second shift MAs completed the second check of the MARs, and the Health and Wellness Director (HWD) completed a third check of the MARs. -She was unsure if Resident #1's April 2025 MAR was checked three times. -She was unsure if Resident #1 was still taking Mirtazapine 7.5mg because she did not work on second shift and the medication was scheduled for bedtime.	D 367			

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D 367	Continued From page 30 -Resident #1 received hospice services and had some recent medication changes, so she was unsure why Mirtazapine was not on his April 2025 MAR. Interview with the Special Care Coordinator (SCC) on 04/22/25 at 4:22pm revealed: -Resident #1 had some recent medication changes because he was receiving hospice services. -The residents' MARs were checked monthly by 2 MAs and the HWD. -She was not responsible for the monthly MAR checks. -She was unsure if Resident #1 was currently taking Mirtazapine. -She was unsure why Resident #1's Mirtazapine was not on his April 2025 MAR. Interview with the HWD on 04/22/25 at 3:42pm revealed: -The residents' MARs were checked each month using a three check system. -Two MAs completed the first and second checks of the residents' MARs, then the third check was completed by the HWD or the Administrator. -She was unsure why Resident #1's Mirtazapine 7.5mg order was not on his MAR. -She was unsure if Resident #1 had been receiving Mirtazapine 7.5mg each night. -She was unsure if Resident #1's April MAR was checked three times. -Resident #1's Mirtazapine 7.5mg order must have been overlooked. Interview with the Administrator on 04/22/25 at 4:35pm revealed: -MAs were responsible for ensuring medication orders were transcribed on the residents' MARs. -The HWD audited the residents' medication	D 367		

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D 367	Continued From page 31 orders to ensure the orders were accurate on the residents' MARs. -The residents' MARs were checked monthly using a three check system. -Two MAs checked the residents' monthly MARs and a third check was completed by the HWD. -If MAs noticed an order was not on a residents' MAR, the MA should check the residents' medication orders to verify if the order was still current. -The MAs should report any issues with the MARs to the HWD or check with the resident's primary care provider (PCP) if there were questions about a medication order. -She was unsure if Resident #1's April 2025 was checked three times if the Mirtazapine order was not on Resident #1's MAR. -The order for Resident #1's Mirtazapine 7.5mg must have been overlooked. Telephone interview with a pharmacist at Resident #1's pharmacy on 04/22/25 at 3:03pm revealed: -The pharmacy last filled Resident #1's Mirtazapine 7.5mg on 03/19/25 for 30 tablets. -The pharmacy had not received any refill requests for Resident #1's Mirtazapine 7.5mg in April 2025. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable. Attempted telephone interview with Resident #1's PCP on 04/23/25 at 4:11pm was unsuccessful.	D 367			