STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073019	A. BUILDING: _____ B. WING _____	06/05/2025

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ROXBORO ASSISTED LIVING OPCO LLC	5660 DURHAM ROAD ROXBORO, NC 27574

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D 000	Initial Comments The Adult Care Licensure Section and the Person County Department of Social Services conducted an annual survey and complaint investigation from 06/03/25-06/05/25.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph 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 1 of 5 exterior exit doors was equipped with a sounding device that was audible throughout the facility when the door was opened and accessible to three residents (#3, #6, #7) residing in the facility, one resident who was constantly disoriented and was known to wander (#3) and two residents who had	D 067		

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D 067	Continued From page 1	D 067		

a diagnosis of dementia and were intermittently disoriented (#6, #7).

The findings are:

Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 120 beds.

Review of the facility's census on 06/03/25 revealed there were 70 residents residing in the facility; two residents were out of the facility.

Observations of the facility on 06/03/25 at various times from 9:00am to 5:15pm revealed:
-There were two exit doors on the sides of the front of the facility; each door had an interior push bar to exit and a keypad beside the door to disarm the alarm.
There were two doors on opposite sides of the back residents' hallways; each door had an interior push bar to exit the facility and was labeled as an emergency exit only.
-There was a main entrance located in the middle of the front of the facility with two sets of double glass doors.
-At 9:00am, the main entrance door was unlocked, and an alarm did not sound when the survey team entered the facility.
-A staff member was sitting at the receptionist's desk at the front entrance of the facility.
-At 5:15pm, the survey team exited the facility; the door alarm did not sound.
-A staff member was sitting at the receptionist's desk at the front entrance of the facility.

Observation of the main entrance door on 06/04/25 at 7:45am revealed:
-No alarm sounded when the survey team entered the facility.

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-No staff members were sitting at the receptionist's desk in the lobby.

Observation of the main entrance door on 06/05/25 at 7:45am revealed:
-No alarm sounded when the survey team entered the facility.
-No staff members were sitting at the receptionist's desk in the lobby.
-There were 7 residents sitting in the lobby.
-There were 11 residents sitting in the hallway outside of the dining room.
-There were no staff members in the hallway.

1. Review of resident #3's current FL2 dated 05/21/2025 revealed:
-Diagnoses included senile degeneration of the brain, anemia, TIA, essential hypertension, and spinal stenosis.
-He was constantly disoriented

Review of Resident 3's Resident Register revealed an admission date of 04/08/25

Review of Resident 3's assessment and care plan dated 05/07/25 revealed:
-The resident was sometimes disoriented.
-The resident was forgetful and needed reminders.

Review of Resident #3's electronic chart notes dated 04/09/25-06/03/25 revealed:
-On 04/09/25 at 6:03am, Resident #3 was very confused, in and out of doors, wandering the hallways exit seeking.
-On 04/09/25 at 12:24pm, Resident #3 was trying to leave the facility.
-On 04/09/25 at 1:24pm, Resident #3 was becoming aggressive and was determined to leave the facility.

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-On 04/19/25 at 6:46pm, Resident #3 was exit seeking.
-On 04/20/25 at 8:55pm, Resident #3 was exit seeking.
-On 05/08/25 at 2:10pm, Resident #3 kept trying to leave the facility.
-On 05/21/25 at 12:25pm, Resident #3 was agitated and exited the facility.
-On 05/25/25 at 8:59pm, Resident #3 was agitated and tried to elope again.
-On 05/29/25 at 10:21am, Resident #3 was trying to leave the facility.
-On 05/30/25 at 9:29am, Resident #3 went out the back door of the facility; staff assisted the resident back inside.

Interview with a personal care aide (PCA) on 06/05/25 at 8:27am revealed:
-Resident #3 had exited the facility on two different occasions that she knew of, and the door alarm sounded.
-Staff heard the alarm and brought the resident back inside the facility.
-She did not recall when the incidents happened.

Interview with a medication aide (MA) on 06/05/25 at 10:03am revealed Resident #3 wandered.

Interview with a second MA on 06/05/25 at 1:54pm revealed Resident #3 wandered and was exit seeking.

Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 2:54pm revealed Resident #3 had exited out of the facility through an alarmed door.

Interview with the Administrator on 06/05/25 at 4:23pm revealed Resident #3 was exit seeking

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D 067	Continued From page 4 and had been given a 30-day notice because the resident was not appropriate for the facility. Refer to the interview with a MA on 06/05/25 at 10:03am. Refer to the interview with Interview with a receptionist on 06/05/25 at 10:25am. Refer to the interview with a second MA on 06/05/25 at 1:54pm. Refer to the interview with the RCC on 06/05/25 at 2:54pm. Refer to the interview with the Administrator on 06/05/25 at 4:23pm. 2. Review of Resident #6's current FL2 dated 03/12/25 revealed: -Diagnoses included dementia and diabetes. -She was intermittently disoriented. Review of Resident 6's Resident Register revealed an admission date of 01/03/24 Review of Resident 6's assessment and care plan dated 05/28/25 revealed: -She was sometimes disoriented. -She was forgetful and needed reminders. Review of Resident #6's electronic chart notes dated 05/01/25 at 10:45am revealed she opened the 100-hall exit door and exited the facility; staff would monitor. Review of a new order request form (undated) Resident #6 needed something for anxiety; she was trying to leave the facility.	D 067		

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Interview with a personal care aide (PCA) on 06/05/25 at 8:27am revealed Resident #6 tried to go out the 200-hall exit door and set the alarm off, but she did not recall when this happened.

Interview with a medication aide (MA) on 06/05/25 at 10:03am revealed Resident #6 wandered.

Interview with a second MA on 06/05/25 at 1:54pm revealed Resident #6 wandered and was exit seeking.

Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 2:54pm revealed Resident #6 had exited out of the facility through an alarmed door.

Interview with the Administrator on 06/05/25 at 4:23pm revealed she had not been told Resident #6 had attempted to exit the facility; she did have dementia but was easily redirected.

Refer to the interview with a MA on 06/05/25 at 10:03am.

Refer to the interview with Interview with a receptionist on 06/05/25 at 10:25am.

Refer to the interview with a second MA on 06/05/25 at 1:54pm.

Refer to the interview with the RCC on 06/05/25 at 2:54pm.

Refer to the interview with the Administrator on 06/05/25 at 4:23pm.

3. Review of Resident #7's current FL2 dated 06/04/25 revealed:

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D 067	Continued From page 6	D 067		

-Diagnoses included Alzheimer's and hypertension.
-She was intermittently disoriented.

Review of Resident 7's Resident Register revealed an admission date of 12/30/24

Review of Resident 7's assessment and care plan dated 04/02/25 revealed:
-She was always disoriented.
-She had significant memory loss and had to be directed.

Review of Resident #7's electronic chart notes dated 03/16/25 revealed she was attempting to leave the facility.

Interview with a personal care aide (PCA) on 06/05/25 at 8:27am revealed Resident #7 tried to go out the 300-hall exit door and set the alarm off, but she did not recall when this happened.

Interview with a medication aide (MA) on 06/05/25 at 10:03am revealed:
-Resident #7 wandered.
-A "couple of weeks ago," Resident #7 kept trying to go out the front door and had to be redirected.

Interview with a second MA on 06/05/25 at 1:54pm revealed Resident #7 tried to open doors and would set the alarms off.

Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 2:54pm revealed:
-Resident #7 pushed the exit doors but did not go out the door because the alarm sounded.
-If the door was not alarmed, she thought Resident #7 might exit the facility.

Interview with the Administrator on 06/05/25 at

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D 067	Continued From page 7 4:23pm revealed she had not been told Resident #7 had attempted to exit the facility. Refer to the interview with a MA on 06/05/25 at 10:03am. Refer to the interview with Interview with a receptionist on 06/05/25 at 10:25am. Refer to the interview with a second MA on 06/05/25 at 1:54pm. Refer to the interview with the RCC on 06/05/25 at 2:54pm. Refer to the interview with the Administrator on 06/05/25 at 4:23pm. _____ Interview with a MA on 06/05/25 at 10:03am revealed: -The front door was usually locked until about 7:00am. -There was no alarm on the front door when it was unlocked. -The front door was the only door that was not alarmed during the day. Interview with a receptionist on 06/05/25 at 10:25am revealed: -She worked from 8:30am-4:30pm. -When she took a break, a staff member watched the desk. -There were (3) residents who were known to exit seek and could not go outside without supervision. -A second receptionist worked from 4:30pm-9:00pm. Interview with a second MA on 06/05/25 at 1:54pm revealed:	D 067		

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D 067	Continued From page 8 -The front door was not alarmed. -There was no receptionist at the front door on the weekend, but staff members tried to make sure someone was at the receptionist's desk. Interview with the RCC on 06/05/25 at 2:54pm revealed: -Sometimes there was a receptionist at the front door on the weekends, and sometimes there was not. -If there was no receptionist at the front door on the weekends, the door would be alarmed. Interview with the Administrator on 06/05/25 at 4:23pm revealed: -The front door was not locked and/or alarmed because the residents complained it felt like the facility was a special care unit (SCU). -There was a receptionist at the front door. -The front door was unlocked and there was no alarm between the hours of 7:45am-9:00pm.	D 067		
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.	D 079		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure the facility was clean and free from hazards as evidenced by multiple unsecured oxygen tanks in the spa room.

The findings are:

According to guidance from the National Fire Protection Association (NFPA) compressed oxygen (O2) tanks must be secured in a rack or stand to prevent tipping over.

Observation of the spa room on 06/03/25 at 10:16am revealed:
-Multiple oxygen tanks were stored inside the spa room.
-There were 8 oxygen tanks standing on the floor that were not secured in a rack/crate.
-There was no gauge on the tanks to indicate the amount of oxygen in the tanks.

Interview with two housekeepers on 06/04/25 between 10:51am-10:55am revealed they had not seen any oxygen tanks at the facility, "just the oxygen machines".

Interview with a personal care aide (PCA) on 06/04/25 at 10:57am revealed:
-Oxygen tanks were stored in a rack/crate to keep the cylinder from turning over.
-When a resident was going out the resident would be given an oxygen tank to take with them if needed.
-When the resident returned to the facility, whoever was working took the oxygen tank and returned it to the room where the oxygen was stored.

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D 079	Continued From page 10 -She had not noticed any oxygen tanks not being in a rack/crate. Interview with the Director of Maintenance on 06/04/25 at 3:20pm revealed: -The medication aides (MA) were responsible for the oxygen tanks. -Oxygen tanks should be stored in a rack/crate and not sitting directly on the floor. -He had not noticed any oxygen tanks not being in a rack/crate. Interview with a MA on 06/04/25 at 3:28pm revealed: -She did not know there were oxygen tanks in the spa room. -Portable oxygen tanks were stored in the medication room. -She had not been told to put oxygen tanks anywhere else. Interview with the Resident Care Coordinator on 06/04/25 at 3:40pm revealed: -All oxygen tanks were required to be stored in a rack/crate. -The MAs were responsible for putting portable oxygen tanks back in the storage room. -She had not been in the oxygen storage room since "last week." -She did not notice there were oxygen tanks not stored in a rack/crate. -It was important for oxygen tanks to be stored in a rack/crate so they would not get knocked over because they could bust. Interview with the Administrator on 06/05/25 at 5:16pm revealed: -The caregivers, PCAs/MAs were responsible for putting oxygen tanks away. -The oxygen tanks should be stored in a	D 079		

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D 079	Continued From page 11 rack/crate to keep the tanks from falling.	D 079		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care for 1 of 5 sampled residents (#2) related to toenails that needed to be trimmed. The findings are: Review of Resident #2's current FL2 dated 05/28/25 revealed: -Diagnoses included cerebrovascular accident with left-side hemiplegia, hypertension, and muscle weakness. -Resident #2 required assistance with bathing and dressing. Review of Resident #2's Care Plan dated 02/11/25 revealed: -He required extensive assistance with bathing and dressing. -He required limited assistance with grooming. Observation of Resident #2's toenails on 06/03/25 at 9:38am revealed: -The resident's second toenail on his right foot was broken and jagged.	D 269		

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-The third toenail on the right foot had grown past the end of the toe by ½ of an inch and was jagged.
-The fourth toe on the right foot had grown past the end of the toe by ½ of an inch and was curved toward the third toe.
-The toenail on the fifth toe on the right foot had grown past the end of the toe by ½ an inch.
-The fourth toe on the left foot had grown past the end of the toe by 3/4 of an inch.
-The toenail on the fifth toe on the left foot had grown past the end of the toe and had curled over the end.

Interview with Resident #2 on 06/03/25 at 9:38am revealed:
-It had been a long time since anyone had cut his toenails.
-When his socks got twisted on his feet, the socks would get hung on his toenails and cause him pain.

Interview with a personal care aide (PCA) on 06/03/25 at 9:40am revealed:
-A podiatrist came to the facility to cut the residents' toenails.
-If a resident was not on the podiatry list, the resident's toenails could not be cut.
-She did not know who decided which residents' names would be on the list.
-She had noticed Resident #2's toenails needed to be trimmed and had told the medication aide (MA).

Interview with a MA on 06/05/25 at 10:03am revealed:
-No one had told her Resident #2's toenails needed to be cut.
-The PCA should let the MA know when a resident's toenails needed to be cut.

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-She would let the Resident Care Coordinator (RCC) know when a resident's toenails needed to be cut.

Interview with the RCC on 06/05/25 at 2:54pm revealed:
-Someone should have let her know Resident #2's toenails needed to be cut.
-She had been notified today, 06/05/25, that Resident #2's toenails needed to be cut.
-She was concerned that Resident #2's toenails were long because he could cut himself and the toenails could be painful.

Telephone interview with Resident #2's primary care provider's (PCP) medical assistant on 06/04/25 at 3:56pm revealed:
-Resident #2's toenails should be kept trimmed.
-If the staff at the facility did not cut the residents' toenails, Resident #2 would need an appointment with a podiatrist.
-Long toenails could cause skin tears and put the resident at risk for an infection.

Interview with the Administrator on 06/05/25 at 4:15pm revealed:
-The PCAs could not cut a resident's toenails, but they could file a resident's toenails.
-The PCAs stated they had not been trained but "we have trained them".
-She expected the PCAs to let her know when a resident's toenails were long and she would put the resident's name on the podiatry list.
-She was aware Resident #2's toenails needed to be cut and had tried to get him into podiatry.
-She could not recall what happened when she tried to get Resident #2 to be seen by the podiatrist.

Attempted telephone interview with the facility's

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROXBORO ASSISTED LIVING OPCO LLC	5660 DURHAM ROAD ROXBORO, NC 27574

(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 269	Continued From page 14 contracted podiatrist on 06/05/25 at 4:54pm was unsuccessful.	D 269		
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 follow-up for 1 of 2 sampled residents (#2) whose leg brace needed new straps. The findings are: Review of Resident #2's current FL2 dated 05/28/25 revealed: -Diagnoses included cerebrovascular accident with left-side hemiplegia, hypertension, and muscle weakness. -Resident #2 required assistance with bathing and dressing. Review of Resident #2's Care Plan dated 02/11/25 revealed: -He required extensive assistance with bathing and dressing. -He required limited assistance with grooming. Review of a physician's order dated 03/06/25 revealed an order to obtain straps for Resident #2's leg brace. Observation of Resident #2 on 06/03/25 at 9:38am revealed:	D 273		

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D 273	Continued From page 15	D 273		

-He was sitting in his wheelchair.
-He was not wearing a leg brace.

Observation of Resident #2's leg brace on 06/04/25 at 10:46am revealed:
-The leg brace was on the floor behind a chair in the resident's room.
-The leg brace was made out of molded plastic.
-The leg brace would be attached with Velcro straps.
-One of the Velcro straps was broken.
-The second Velcro strap hooking mechanism was no longer functioning.

Interview with Resident #2 on 06/04/25 at 10:46am revealed:
-When he wore his leg brace, he could walk with a walker.
-His leg brace had been broken for "about a year".
-He would like his leg brace repaired.

Interview with a medication aide (MA) on 06/05/25 at 10:03am revealed:
-Before she came in on the first shift, the staff on the third shift had already put on Resident #2's leg brace.
-She saw the straps were broken on Resident #2's leg brace, but she did not recall when.
-She did not recall if she let anyone know the straps were broken on Resident #2's leg brace.

Telephone interview with Resident #2's primary care provider's (PCP) medical assistant on 06/04/25 at 3:56pm revealed:
-She had received several calls from the facility about Resident #2's brace but the PCP was not the one who ordered the brace and did not know anything about it.
-The PCP had written an order to have the straps

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D 273	Continued From page 16 added to Resident #2's brace. -The facility should have taken care of having Resident #2's brace repaired. Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 2:54pm revealed: -She saw the order today, 06/05/25, from March 2025 to order straps for Resident #2's brace. -Had she seen the order she would have called Resident #2's PCP and asked for a referral to be seen for evaluation of the leg brace. -Straps for Resident #2's leg brace were an order and should have been carried out. Interview with the Administrator on 06/05/25 at 4:15pm revealed: -She found out today, 06/05/25, that Resident #2's leg brace was broken. -She expected the RCC to have asked for a referral to get the leg brace repaired.	D 273		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days.	D 285		

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D 285	Continued From page 17	D 285		

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to have a 5-day supply of non-perishable foods based on the census and the menus in the facility as evidence of the food pantry having limited proteins and green vegetables stored.

The findings are:

Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 120 beds.

Review of the facility's census on 06/03/25 revealed there were 70 residents residing in the facility; two residents were out of the facility.

Observations of the food pantry in the facility 06/04/25 at 10:33am revealed:
-There were 3 cans of salmon with a serving of 21 one-half cup 4-ounce servings per can: 63 servings.
-There was 1 can of collard greens with 22 one-half cup servings per can: 22 servings.

Observation of a closet in the dining room on 06/04/25 at 3:00pm revealed:
-There were 10 cans of green beans with a serving of 3.5 one-half cup servings per can: 35 servings.
-There were 6 cans of petite tomatoes with a serving of 3.5 per one-half cup servings per can: 21 servings.

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D 285	Continued From page 18 Review of the facility's lunch menu for one week revealed: -On Monday, 1 ounce (oz) of baked chicken, and ½ cup vegetable blend were to be served. -On Tuesday, 3 oz of braised beef tips and ½ cup of seasoned carrots were to be served. -On Wednesday, 3 ounces of lasagna and 1 cup of tossed salad were to be served. -On Thursday, 3 oz roast beef and ½ cup of green beans were to be served. -On Friday, 8 oz of chicken and ½ cup of beets were to be served. -On Saturday, 4.5 oz ham and ½ cup of broccoli were to be served. -On Sunday, 4 oz chicken and ½ cup of spinach were to be served. -A total of 26.5 oz of meat and 4 cups of green vegetables were needed to be served to each resident for the lunch menu for one week. Review of the facility's dinner menu for the week revealed: -On Monday, 2 oz of salmon and ½ cup of yellow squash were to be served. -On Tuesday, 2 oz of barbeque on a bun and ½ cup of cole slaw were to be served. -On Wednesday, 2 oz of chicken and ½ cup of mixed vegetables were to be served. -On Thursday, 2 ounces of kielbasa and ½ cup of sauerkraut were to be served. -On Friday, 2 oz fish sandwich and ½ cup carrot raisin salad were to be served. -On Saturday, 2 ounces of beef and ½ cup of brussels sprouts were to be served. -On Sunday, 2 oz of pizza and 1 cup of mixed green salad were to be served. -A total of 14 oz of meat and 4 cups of green vegetables were needed to be served to each resident for the dinner menu for one week.	D 285		

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D 285	Continued From page 19 Interview with the Dietary Manager on 06/04/25 at 2:35pm revealed she did not know the facility needed to have a 5-day supply of non-perishable food items available to be served. Interview with the Administrator on 06/05/25 at 4:05pm revealed: -She knew there was not enough food for a 5-day supply of non-perishable food supply. -She had requested the previous Dietary Manager to restock the pantry after a fire in the kitchen and the Dietary Manager did not do so.	D 285		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents were provided with non-disposable place settings including plates, forks, knives, spoons, and cups during meal service when eating in their rooms. The findings are:	D 286		

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D 286	Continued From page 20 Observation of a resident's breakfast meal service on 06/03/25 at 9:30am revealed: -The resident was served breakfast in her room. -The resident was eating cereal in a disposable bowl with a plastic spoon. Interview with the resident on 06/03/25 at 9:30am revealed: -She ate all her meals in her room. -Her meals were served on disposable plates. -Her drinks were served in disposable cups. -She was served plastic utensils. Observation of a second resident's lunch meal service on 06/03/25 at 12:30pm revealed: -The resident was served lunch in his room. -The resident's lunch was served on a disposable plate. -The resident was served iced tea in a disposable cup. -A plastic knife and fork were provided. Interview with a dietary aide on 06/04/25 at 2:09pm revealed condiments and drinks were done by the personal care aides (PCA) for residents who ate their meals in their rooms. Interview with a Personal Care Aide (PCA) on 06/04/25 at 3:31pm revealed: -Plastic utensils and disposable cups were used for residents who ate their meals in their rooms. -He did not know disposable silverware and cups could not be used. Interview with the Dietary Manager on 06/04/25 at 2:35pm revealed: -Plastic utensils and disposable cups were used for residents who ate their meals in their rooms. -Sometimes they used a disposable hinged	D 286		

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D 286	Continued From page 21 container for the residents who ate their meals in their rooms. -She did not know disposable silverware and cups could not be used. Interview with the Administrator on 06/05/25 at 4:05pm revealed: -She knew there had been concerns with things getting broken when meals were served in the residents' rooms. -She had requested staff not to use disposable items for residents who ate meals in their rooms. -She had requested the previous Dietary Manager order more dinnerware items as there was not enough.	D 286		
D 291	10A NCAC 13F .0904(c)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (2) Menus shall be maintained in the kitchen and identified as to the current menu day for guidance of food service staff. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to have therapeutic menus in the kitchen for the guidance of food service staff. The findings are:	D 291		

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D 291	Continued From page 22 Review of resident diet orders on 06/03/25 revealed there were nine residents who had an order for controlled carbohydrate diets, four residents who had orders for no added salt (NAS) diets, and two residents who had orders for mechanical soft diets. Review of the facility's menus revealed a therapeutic diet spreadsheet was available. Observation of the kitchen on 06/04/25 at 10:39am revealed: -There was a handwritten list of the menu for the day. -There was no therapeutic menu posted in the kitchen. Observation of the kitchen on 06/04/25 at 10:39am revealed: -There was a list of residents by table that had what breakfast food items they liked. -There was an asterisk beside 18 residents' names. -There was a handwritten note indicating the asterisk meant the resident was diabetic. -There was no documentation to indicate which residents had a diet order for controlled carbohydrates, NAS, or mechanical soft diets. Interview with a cook on 06/04/25 at 2:17pm revealed: -There was one [named] resident who was on a controlled carbohydrate diet. -The [named] resident would get baked meat if all the other residents had fried meat. -She followed the menu that was given to her, -She did not have a therapeutic menu to use to prepare the residents' meals/plates.	D 291		

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D 291	Continued From page 23 Interview with the Dietary Manager on 06/04/25 at 2:35pm revealed: -She did not know there was a therapeutic menu spreadsheet in the kitchen. -She was still going through items in the kitchen/office from the previous Dietary Manager. Interview with the Administrator on 06/05/25 at 4:05pm revealed: -The dietary staff should have had the therapeutic menu in the kitchen to use for preparing meals. -There had been recent changes in the dietary department and all the staff had not been trained to know what to do.	D 291		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to maintain a current listing of residents with physician ordered therapeutic diets for guidance of food service staff. The findings are:	D 309		

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D 309	Continued From page 24 Review of resident diet orders on 06/03/25 revealed there were nine residents who had an order for controlled carbohydrate diets, four residents who had orders for no added salt (NAS) diets, and two residents who had orders for mechanical soft diets. Observation of the breakfast meal service on 06/04/25 at 8:11am revealed a resident who had a mechanical soft diet order, had strips of bacon. Observation of the kitchen on 06/04/25 at 10:39am revealed: -There was a list of residents by table that had what breakfast food items they liked. -There was an asterisk beside 18 residents' names. -There was a handwritten note indicating the asterisk meant the resident was diabetic. -There was no documentation to indicate which residents had a diet order for controlled carbohydrates, NAS, or mechanical soft diets. Interview with a dietary aide on 06/04/25 at 2:09pm revealed: -Residents were offered a regular plate or an alternate plate at meals. -She knew some residents had chewing problems. -If a pork chop was served, staff would cut the pork chop up for a resident who had chewing problems. -There was one resident who had a pureed diet. -There was one resident who could only have soft food because of a choking hazard. -A resident could request a vegetable plate. -Other than those, all other plated food was the same.	D 309		

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D 309	Continued From page 25 Interview with a cook on 06/04/25 at 2:17pm revealed: -She used the diet list that was posted in the kitchen to prepare meals and plate the food. -She named three residents who had chopped diets. -There was one resident on a controlled carbohydrate diet. Interview with the Dietary Manager on 06/04/25 at 2:35pm revealed: -There was a list in the kitchen that staff used as a guide to prepare meals. -The list had the residents listed who were diabetic. -Four named residents were on soft diets. -A [named] resident should have received chopped meats. Interview with the Administrator on 06/05/25 at 4:05pm revealed the diet list in the kitchen should have been updated and accurate.	D 309		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's	D 344		

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D 344	Continued From page 26 record. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to clarify a medication order for 1 of 5 sampled residents (#2)related to an order for a weekly blood pressure check, a medication used to treat pain, a topical cream, and compression stockings. The findings are: Review of Resident #2's current FL2 dated 05/28/25 revealed diagnoses included cerebrovascular disease (CVA) with left-side hemiplegia, hypertension, hyperlipidemia, and muscle weakness. a. Review of Resident #2's current FL2 dated 05/28/25 revealed an order for weekly blood pressure (BP) checks. Review of Resident #2's signed physician's order dated 05/28/25 revealed no order for weekly BP checks. Review of Resident #2's May 2025 electronic medication administration records (eMAR) from 05/28/25 to 05/31/25 revealed there was no entry for weekly blood pressure check and no documentation of any BP readings for Resident #2. Review of Resident #2's June 2025 eMAR from 06/01/25-06/04/25 revealed there was no entry for weekly blood pressures and no documentation of any BP readings for Resident #2. Interview with Resident #2 on 06/04/25 at 10:46am revealed:	D 344		

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-Staff did not check his BP every day.
-he did not recall the last time his BP was checked.

Telephone interview with Resident #2's primary care provider's (PCP) medical assistant on 06/04/25 at 3:56pm revealed:
-When the FL2 was received at the PCP's office, information was already filled in on the form.
-She wrote in weekly BP checks on Resident #2's FL2 dated 05/28/25 because it had been on the previous FL2 and she thought the staff at the AL had forgotten to write it in.
-She could see that weekly BP checks were on the 2022 and 2024 FL-2s.
-If Resident #2 did not need weekly BP checks, the order should have been clarified.

Interview with a medication aide (MA) on 06/05/25 at 10:03am revealed Resident #2 did not have an order on the eMAR for weekly BP checks.

Refer to the interview with a MA on 06/05/25 at 7:50am.

Refer to the telephone interview with a pharmacy technician with the facility's contracted pharmacy on 06/05/25 at 3:30pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/05/25 at 2:54pm.

Refer to the interview with the Administrator on 06/05/25 at 4:05pm.

b. Review of Resident #2's current FL2 dated 05/28/25 revealed a handwritten note to see the attachment for the medication list.

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Review of Resident #2's attached medication list dated 05/28/25 revealed an order for triamcinolone acetonide 0.1% cream (used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions) apply to the affected area once daily.

Review of Resident #2's signed physician's order dated 05/28/25 revealed an order for triamcinolone acetonide 0.1% cream apply to the affected area as needed for leg redness.

Review of Resident #2's May 2025 eMAR from 05/28/25-05/31/25 revealed:
-There was no entry for triamcinolone acetonide 0.1% cream apply to the affected area as needed for leg redness.
-There was no documentation that triamcinolone cream had been used from 05/28/25-05/31/25.

Review of Resident #2's June 2025 eMAR from 06/01/25-06/04/25 revealed:
-There was no entry for triamcinolone acetonide 0.1% cream apply to the affected area as needed for leg redness.
-There was no documentation that triamcinolone cream had been used from 06/01/25-06/04/25.

Observation of Resident #2's medication on hand on 06/04/25 at 9:49am revealed there was no triamcinolone acetonide 0.1% cream available for administration.

Interview with Resident #2 on 06/04/25 at 10:46am revealed he used a cream daily but he did not know the name of the cream.

Telephone interview with Resident #2's PCP medical assistant on 06/04/25 at 3:56pm revealed if the attached medication list on the FL2 did not

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match the signed physician's orders, the staff should have clarified which order was correct.

Interview with a MA on 06/05/25 at 10:03am revealed she administered Resident #2's medications based on the eMAR.

Refer to the interview with a MA on 06/05/25 at 7:50am.

Refer to the telephone interview with a pharmacy technician with the facility's contracted pharmacy on 06/05/25 at 3:30pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/05/25 at 2:54pm.

Refer to the interview with the Administrator on 06/05/25 at 4:05pm.

c. Review of Resident #2's current FL2 dated 05/28/25 revealed a handwritten note to see the attachment for the medication list.

Review of Resident #2's attached medication list dated 05/28/25 revealed there was no order for acetaminophen (used to treat mild pain).

Review of Resident #2's signed physician's order dated 05/28/25 revealed an order for acetaminophen 500mg, take two tablets twice daily scheduled at 8:00am and 8:00pm.

Review of Resident #2's May 2025 eMAR from 05/28/25-05/31/25 revealed:
-There was an entry for acetaminophen 500mg, take two tablets twice daily scheduled at 8:00am and 8:00pm.
-There was documentation that acetaminophen 500mg, take two tablets twice daily had been

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D 344	Continued From page 30 administered from 05/28/25-05/31/25. Review of Resident #2's June 2025 eMAR from 06/01/25-06/04/25 revealed: -There was an entry for acetaminophen 500mg, take two tablets twice daily scheduled at 8:00am and 8:00pm. -There was documentation that acetaminophen 500mg, take two tablets twice daily had been administered from 06/01/25-06/03/25 and at 8:00am on 06/04/25. Observation of Resident #2's medications on hand on 06/04/25 at 9:49am revealed: -There were 4 medication cards of 30 tablets of acetaminophen 500mg with the directions to take tablets twice daily dispensed on 05/14/25. -There were 63 tablets available for administration in the medication cards. Telephone interview with Resident #2's PCP medical assistant on 06/04/25 at 3:56pm revealed if the attached medication list on the FL2 did not match the signed physician's orders, the staff should have clarified which order was correct. Interview with Resident #2 on 06/04/25 at 10:46am revealed he took acetaminophen every day. Interview with a MA on 06/05/25 at 10:03am revealed Resident #2 she administered Resident #2's medications based on the eMAR. Refer to the interview with a MA on 06/05/25 at 7:50am. Refer to the telephone interview with a pharmacy technician with the facility's contracted pharmacy on 06/05/25 at 3:30pm.	D 344		

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D 344	Continued From page 31 Refer to the interview with the Resident Care Coordinator (RCC) on 06/05/25 at 2:54pm. Refer to the interview with the Administrator on 06/05/25 at 4:05pm. d. Review of Resident #2's current FL2 dated 05/28/25 revealed no order for the use of compression stockings. Review of Resident #2's signed physician's order dated 05/28/25 revealed an order to apply compression stockings in the morning and remove them at bedtime. Review of Resident #2's May 2025 eMAR from 05/28/25-05/31/25 revealed: -There was an entry to apply compression stockings in the morning and remove them at bedtime scheduled at 6:00am and 6:00pm. -There was documentation compression stockings had been applied at 6:00am and removed at 6:00pm from 05/28/25-05/31/25. Review of Resident #2's June 2025 eMAR from 06/01/25-06/04/25 revealed: -There was an entry to apply compression stockings in the morning and remove them at bedtime scheduled at 6:00am and 6:00pm. -There was documentation that compression stockings had been applied at 6:00am and removed at 6:00pm from 06/01/25-06/02/25 and applied at 6:00am on 06/03/25. Observation of Resident #2's legs on 06/03/25 at 9:39am revealed Resident #2 had a compression stocking on his left leg; he did not have a compression stocking on his right leg.	D 344		

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D 344	Continued From page 32 Interview with Resident #2 on 06/03/25 at 9:39am revealed he only wore a compression stocking on his left leg because he did not have any swelling in his right leg. Telephone interview with Resident #2's PCP medical assistant on 06/04/25 at 3:56pm revealed; -She did not know if Resident #2 was only wearing his compression stockings on one leg or both. -If he was only wearing the compression stockings on one leg, the order could be written to clarify. Interview with a MA on 06/05/25 at 10:03am revealed Resident #2 only wore a compression stocking on one leg underneath his leg brace. Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 2:54pm revealed: -Resident #2 wore a compression stocking on his left leg only. -The order did not specify which leg, but she was following what was done when she started working at the facility. Telephone interview with a pharmacy technician with the facility's contracted pharmacy on 06/05/25 at 3:30pm revealed if Resident #2 was only wearing a compression stocking on one leg, the order should be written for one leg. Refer to the interview with a MA on 06/05/25 at 7:50am. Refer to the telephone interview with a pharmacy technician with the facility's contracted pharmacy on 06/05/25 at 3:30pm.	D 344		

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D 344	Continued From page 33 Refer to the interview with the Resident Care Coordinator (RCC) on 06/05/25 at 2:54pm. Refer to the interview with the Administrator on 06/05/25 at 4:05pm. _____ Interview with a MA on 06/05/25 at 7:50am revealed: -She did not do anything with FL2s. -She reviewed signed physician's orders to make sure they matched the eMAR and medications on hand. Telephone interview with a pharmacy technician with the facility's contracted pharmacy on 06/05/25 at 3:30pm revealed: -The last signed physician's orders they had on file were dated 02/27/25. -If they had received the FL2 and signed physician's orders dated 05/28/25, they would have clarified the orders. Interview with the Resident Care Coordinator (RCC) on 06/05/25 at 2:54pm revealed: -She did not see Resident #2's FL2 when it was returned with the signed physician's orders. -Whoever received the FL2 should have faxed the FL2 to the pharmacy and the pharmacy would have clarified the order. Interview with the Administrator on 06/05/25 at 4:05pm revealed: -Signed physician's order and FL2s should be given to the supervisor, nurse, or RCC to be reviewed and filed. -The FL2 and signed physician's orders should be faxed to the pharmacy. - The FL2 and signed physician's orders should match and if they did not, the supervisor, nurse, or RCC, were responsible for reaching out to the	D 344		

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D 344	Continued From page 34 PCP to get clarification.	D 344		
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 record reviews and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#5) including a medication used to prevent blood clots. The findings are: Review of Resident #5's current FL2 dated 03/12/25 revealed diagnosis included deep vein thrombosis. Review of Resident #5's signed physician's orders dated 02/26/25 revealed there was an order for Coumadin (used to thin the blood to prevent blood clots) 5mg daily at 2pm from Monday to Sunday. A review of Resident #5's record revealed an international normalized ratio (INR) (a measurement of how long it takes blood to clot) result of 3.10. Review of a physician's order dated 05/14/25	D 358		

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revealed to hold coumadin dose on 05/14/25 for one day then resume current regimen due to INR of 3.10.

Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for coumadin 5mg daily on Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, and Sunday with a scheduled administration time of 2:00pm.
-There was documentation coumadin 5mg was administered daily from 05/01/25 to 05/31/25 with an exception on 05/11/25 that was documented as "given to family to give later".
-There was no documented instructions to hold coumadin 5mg on 05/14/25.
-Coumadin 5mg was documented as administered on 05/14/25.

Interview with a medication aide (MA) on 06/04/25 at 2:24pm revealed:
-If there was an order to hold a medication, it would be grayed out on the eMAR so it could not be given.
-She did not enter orders into the system.
-She recalled someone told her to hold the coumadin for Resident #5 but she could not recall when it was.

A telephone interview with a pharmacist from the facility's contracted pharmacy on 06/05/25 at 3:20pm revealed:
-The facility faxed orders to the pharmacy for entry.
-There was an order dated 05/14/25 to hold Coumadin dose on 05/14/25 for Resident #5.
-The pharmacy could have entered the coumadin hold order but the way the system worked, the facility would not be able to see it.

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-The facility should enter medication hold orders into the eMAR.

Based on observations, record review, and staff interviews, it was determined Resident #5 was not interviewable.

Interview with Resident #5's primary care provider (PCP) on 06/04/25 at 2:20pm revealed:
-She usually ordered INR checks on Resident #5 monthly.
-Resident #5's INR results were typically stable.
-On 05/13/25, Resident #5's INR was elevated, so she wrote an order to hold Coumadin for one dose then resume current regimen.
-When she wrote an order at the facility, she left it for the Resident Care Coordinator (RCC) or nurse at the facility and they processed them.
-She was not aware the coumadin did not get held on 05/14/25.
-If the coumadin was not held as ordered, the INR could continue to rise, putting Resident #5 at risk for bleeding.
-She expected her orders to be carried out.

Interview with the RCC on 06/04/25 at 3:30pm revealed:
-When the PCP wrote orders to hold medications, she entered the order into the eMAR.
-The medication that was ordered to be held would show as gray on the eMAR and would not allow the MAs to administer the medication.
-She implemented an order tracking for but did not put it into place until the middle of May which might have been after the order was written to hold Resident #5's coumadin on 05/14/25.
-The order for Resident #5's coumadin dose to be held on 05/14/25 must have been missed.

Interview with the Administrator on 06/05/25 at

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D 358	Continued From page 37 4:20pm revealed: -There were three people who could enter orders, the RCC, the Supervisor in Charge (SIC), and the nurse. -There was not one designated person that processed orders and that was a problem because orders could get missed. -She expected orders to be followed.	D 358		
D 406	10A NCAC 13F .1009 (b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow up on a pharmacy review recommendation for 2 of 5 sampled residents (#2 and #5). The findings are: 1. Review of Resident #5's current FL2 dated 04/30/25 revealed diagnoses included atrial fibrillation. Review of Resident #5's record revealed the last INR (International Normalized Ratio (a test to measure how long it takes blood to clot) result was dated 01/20/25. Review of a quarterly pharmacy drug review for	D 406		

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Resident #5 dated 11/23/24 revealed:
-It was recommended that INRs were being done as ordered and placed in the chart.
-The last INR result in the chart was dated 01/20/25.
-There was no response indicated to the recommendation.

Attempted telephone interview with Resident #5's primary care provider (PCP) on 06/04/25 at 2:10pm was unsuccessful.

Telephone interview with the facility's contracted Pharmacist on 06/05/25 at 8:12am revealed:
-When she completed the quarterly medication review on 04/28/25 for Resident #5, she recommended the facility staff to ensure INRs were being done and placed on the chart.
-She did not find any INR results on Resident #5's chart since January 2025.
-It was important for the INR results to be on the chart so she could review them as part of the medication review.
-She needed to ensure the INRs were being done as ordered and any orders based on the results were carried out.

Refer to telephone interview with the facility's contracted Pharmacist on 06/05/25 at 8:12am.

Refer to interview with the Resident Care Coordinator (RCC) on 06/05/25 at 2:55pm.

Refer to interview with the Administrator on 06/05/25 at 4:20pm.

2. Review of Resident #2's current FL2 dated 05/28/25 revealed diagnoses included cerebrovascular disease (CVA) with left-side hemiplegia, hypertension, hyperlipidemia, and

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D 406	Continued From page 39 muscle weakness. Review of a quarterly pharmacy drug review for Resident #2 dated 11/23/24 revealed: -There was a recommendation for triamcinolone 0.1% cream (used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions) apply topically to affected areas daily as needed to please specify areas of application. -There was a second recommendation for ketoconazole 2% cream (used to treat infections caused by a fungus or yeast) applied topically to the left groin daily, to please clarify the length of the therapy. -There was no response indicated to the recommendation. Refer to telephone interview with the facility's contracted Pharmacist on 06/05/25 at 8:12am. Refer to interview with the Resident Care Coordinator (RCC) on 06/05/25 at 2:55pm. Refer to interview with the Administrator on 06/05/25 at 4:20pm. _____ Telephone interview with the facility's contracted Pharmacist on 06/05/25 at 8:12am revealed: -She completed medication reviews on all the residents quarterly. -When her review was complete, she emailed the complete list of the residents she completed medication reviews on and the recommendations to the RCC. -She also went over the review with the RCC and asked if they had any questions. -It was her understanding, that the RCC was responsible for making sure the recommendations were acted on.	D 406		

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D 406	Continued From page 40 -She had seen recommendations that were acted on in the past but she thought the current RCC, who was new, did not know. Interview with the RCC on 06/05/25 at 2:55pm revealed: -She just started in the RCC role in April 2025. -The pharmacy consultant emailed the list of the medication reviews to her. -She did not print them out. -She did not do anything with the pharmacy consultants' recommendations because she did not know what to do with them. Interview with the Administrator on 06/05/25 at 4:20pm revealed: -The RCC and the nurse were responsible for making sure the consultant pharmacist's recommendations were being acted on. -The recommendations were supposed to be addressed by the physician or the nurse, carried out, and signed. -She thought they may not be getting done because there were two people responsible and they may not know what their individual responsibilities were.	D 406		