STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092229	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAL'S PLACE AT BROOKHAVEN	6112 WINTHROP DRIVE RALEIGH, NC 27612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on August 28, 2025.	C 000	- Admin immediately removed medication from resident #3 room.	8/28/25
C 350	10A NCAC 13G .1005 (a and b) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) The facility shall notify the physician when: (1) there is a change in the resident's mental or physical ability to self-administer; (2) the resident is non-compliant with the physician's orders; or (3) the resident is non-compliant with the facility's medication policies and procedures. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 3 sampled residents (#3) who self-administered medications had orders to self-administer medications that were kept in the resident's room	C 350	- Monitor system in place daily and as needed per each outside ordered delivered. - Admin immediately spoke to Resident #3 family and reviewed contracts and house rules/policies. - Admin spoke to All residents as well as All POAs and reviewed house rules, contracts and house/state policies.	8/29/25 8/28/25 8/29/25

Reviewed and acknowledged 09/22/25 KC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092229	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAL'S PLACE AT BROOKHAVEN	6112 WINTHROP DRIVE RALEIGH, NC 27612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 350	Continued From page 1 including a medication used to treat pain and a medication used to treat constipation. The findings are: Review of Resident #3's current FL2 dated 03/04/25 revealed: -Diagnoses included multiple myeloma, chronic obstructive pulmonary disease (COPD), muscle weakness, hemiplegia and hemiparesis following cerebral infarction, unspecified fall, other persistent atrial fibrillation, and generalized idiopathic epilepsy and epileptic syndrome. -There was an order for Tylenol 325mg 2 tabs 4 times a day as needed for pain. (Tylenol is a medication used to treat pain.) -There was no order for Tylenol rapid released 500mg. -There was an order for Dulcolax 5mg 1 tablet as needed for constipation. (Dulcolax is a medication used to treat constipation.) -There was no order for Phillips laxative caplets. (Phillips laxative is a medication used to treat constipation.) Observation of Resident #3's room on 08/28/25 at 8:35am revealed: -There was an empty Tylenol rapid release 500mg bottle on the resident's over the bed table with a quantity of 100 pills on the label. -There was a bottle of Phillips laxative caplets with 2 pills remaining on the resident's over the bed table. Observation of a grocery delivery order for Resident #3 at 9:15am revealed there was a new bottle of Tylenol rapid release pills 500mg in the bag. Review of Resident #3's record on 08/28/25	C 350	-Staff will be present next to resident and watch as resident open any outside packages. 8/28/25 -Staff and Admin will check resident room and table daily/hourly 8/29/25 -Staff will sign/date/time to confirm room has been checked on daily checklist. 8/29/25 -Admin spoke to family (POA) and informed that this was a warning. If happens again Admin will notify POA and discuss stopping all outside deliveries. Also discussed with Resident #3 as well. 8/29/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092229	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAL'S PLACE AT BROOKHAVEN	6112 WINTHROP DRIVE RALEIGH, NC 27612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 350	Continued From page 2 revealed he did not have an order to self-administer medication from his primary care provider (PCP). Interview with Resident #3 on 08/28/25 at 8:35am, 3:55pm and 5:59pm revealed: -He was given permission by his PCP to keep medications in his room. -He ordered a bottle of Tylenol today for delivery with a grocery order. -The Tylenol rapid release 500mg bottle that was in his room was brought to him by his family member a few weeks ago because he had a toothache. -The Tylenol rapid release 500mg bottle did not contain 100 pills when he received it. -The Tylenol rapid release 500mg bottle was not a new bottle but was brought from the home of a family member. -He was not sure how many pills were in the Tylenol rapid release 500mg bottle when his family member brought it to him. -He did not recall how often he took the Tylenol rapid release 500mg. -He did not tell facility staff that he had a tooth ache and needed pain medication. -He was aware his PCP prescribed pain medication for him, and it was available at the facility. -A family member brought him the Phillips laxative caplets from their home. -Due to chemotherapy, he went back and forth between being constipated and having diarrhea. -The Phillips laxative caplets worked better than the medication his PCP prescribed for him. -He did not tell facility staff that the Phillips laxative caplets worked better than the medication the PCP prescribed. -He did not tell the PCP that the Phillips laxative caplets worked better than the prescribed	C 350	Monitor system in place daily and hourly. Also as needed per outside delivery. 8/29/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092229	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAL'S PLACE AT BROOKHAVEN	6112 WINTHROP DRIVE RALEIGH, NC 27612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 350	Continued From page 3 medication. -Facility staff told him all medications are supposed to be locked up but he forgot. -Facility staff did not know he had medications in his room because his family member brought the medication directly to his room and he hid the medication on his over the bed table amongst the other items on the table. -He hid the medication because he did not want staff to take the medication away from him. -He was not asked if he wanted a self-administration order because he kept the medications "a secret." -As long as he was getting the medications that he ordered himself, he was happy. -He was not interested in self-administration because he was satisfied with the medications that he was "keeping a secret." Interview with the Administrator on 08/28/25 at 9:15am and 5:58pm revealed: -She was at the facility daily. -She was in the facility yesterday (08/27/25) until 5:00pm and did not see any medication is Resident #3's room. -She felt Resident #3 was hiding the medication so she would not see it. -Resident #3 does not have a self-administration order. -Resident #3's family member brought over the counter (OTC) medications for the resident. -She spoke with Resident #3's family member last week about his medications and advised the facility had to be in control of all his medications and all medications had to be locked up. -Resident #3 was informed that he could not keep medication in his room and that he had to have a order from his PCP to do so. -She did not have Resident #3 evaluated for self-administration because she asked Resident	C 350	Monitor system in place daily and hourly. And as needed every outside delivery. 8/29/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092229	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAL'S PLACE AT BROOKHAVEN	6112 WINTHROP DRIVE RALEIGH, NC 27612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 350	Continued From page 4 #3 if he wanted a self-administration order and he said no. -Resident #3 told her he wanted the facility to oversee his medication. -Resident #3 had an order for Tylenol 650mg take 2 325mg tablets 4 times a day as needed. -Resident #3 did not have an order for Tylenol rapid release 500mg. -There was Tylenol 325mg on hand for Resident #3 that could be administered as needed. Telephone interview with the Owner on 08/28/25 at 5:41pm revealed: -She was not aware Resident #3 was keeping medications in his room. -She was informed by the Administrator today (08/28/25) that Resident #3 had medications in his room. -She was not aware that Resident #3 was ordering medications to be delivered to the facility. -There was nothing in place to monitor residents ordering medications or to check for medications in resident rooms because that had not been a problem. -All medications were to be stored in the locked medical cabinet where only a medication aide (MA) and the Administrator had access. Telephone contact with the pharmacist at the facility's contracted pharmacy on 08/28/25 at 4:06pm revealed: -Resident #3 had an order for Tylenol 325mg take 2 tablets every 6 hours as needed for pain. -There was no order for Tylenol rapid release 500mg. -Resident #3 had an order for Dulcolax 5mg 1 tablet every 8 hours as needed for constipation. -There was no order for Phillips laxative caplets. -There was no self-administer order on file for	C 350	Monitor system in place daily and hourly. And as needed every outside delivery. 8/29/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092229	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAL'S PLACE AT BROOKHAVEN	6112 WINTHROP DRIVE RALEIGH, NC 27612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 350	Continued From page 5 Resident #3. -The concern with Resident #3 not having a self-administration order but having medication in his room is that he could be administering medication to himself and then request the same medication from the facility without the facility knowing he had already taken a similar medication. -If Resident #3 received the Tylenol 325mg 2 tablets every 6 hours as well as the Tylenol rapid release 500mg there would be a concern because the maximum dose per day for Tylenol is 3 grams. -Six tablets of 500mg Tylenol rapid release equals 3 grams. -Taking over 3 grams of Tylenol per day could affect the liver or lead to overdose. -There was no concern with the Philips laxative caplets because it was used as a supplement. Attempted telephone interview with Resident #3's family member on 08/28/25 at 4:33pm was unsuccessful. Attempted telephone interview with Resident #3's PCP on 08/28/25 at 4:20pm was unsuccessful.	C 350	Monitor system in place daily and hourly. And as needed every outside delivery. 8/29/25	

Reviewed and acknowledged 09/22/25 KC