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	HAL073018	A. BUILDING: _____ B. WING _____	R-C 12/05/2025

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THE CANTERBURY HOUSE	1284 LEASBURG ROAD ROXBORO, NC 27573

(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 a follow-up survey and complaint investigation from December 2, 2025 to December 5, 2025. The complaint investigation was initiated by the Person County Department of Social Services on September 22, 2025.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled medication aides (MA) (Staff D and Staff E) completed the 5-hour and 10-hour, or 15-hour MA training and completed Medication Skills Competency Validation prior to administering medications. The findings are: 1. Review of Staff D's personnel record revealed: -Staff D was hired as a MA on 11/07/25. -Staff D passed the state written MA examination on 10/31/25.	D 125		

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D 125	Continued From page 1 -There was no documentation Staff D completed the 5-hour and 10-hour or 15-hour training course. -There was no documentation Staff D completed the medication Skills Competency Validation checklist. -There was no employment verification form. Review of a resident's November 2025 electronic medication administration records (eMAR) revealed there was documentation Staff D administered medications on 11/10/25, 11/13/25, 11/15/25, 11/18/25, 11/20/25 and 11/25/25. Attempted telephone interview with Staff D on 12/03/25 at 2:10pm was unsuccessful. Refer to the interview with the Regional Clinical Director on 12/04/25 at 3:00 pm. Refer to the interview with with the Administrator on 12/04/25 at 3:30 pm. 2. Review of Staff E's personnel record revealed: -Staff E was hired as a MA on 11/03/25. -Staff E passed the state written MA examination on 07/13/23. -There was no documentation Staff E completed the 5-hour and 10-hour or 15-hour training course. -There was no documentation Staff E completed the medication Skills Competency Validation checklist. -There was no employment verification form. Review of a resident's November 2025 eMAR revealed there was documentation Staff E administered medications on 11/16/25. Interview with Staff E on 12/03/25 at 2:20pm	D 125		

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D 125	Continued From page 2 revealed: -She had administered medications to residents in November and December. -She completed the 5-hour and 10-hour training course at her former job. -She did not provide documentation of the training when she was hired at this facility. -She was currently working on completing the Medication Skills Competency checklist. -She was not aware she could not administer medications without completing the Medication Skills Competency checklist. Refer to the interview with the Regional Clinical Director on 12/04/25 at 3:00 pm. Refer to the interview with with the Administrator on 12/04/25 at 3:30 pm. _____ Interview with the Regional Clinical Director on 12/04/25 at 3:00 pm revealed: -The Administrator made her aware today, 12/04/25, about the two MAs who administered medications without completing the 5-hour and 10-hour, or 15-hour MA training and Medication Skills Competency Validation checklist. -The Administrator was responsible for ensuring all MAs met the eligibility requirements before administering medications. -Her expectations would be for all MAs to complete all requirements prior to administering medication to residents. Interview with the Administrator on 12/04/25 at 3:30 pm revealed: -He was not aware MAs were required to have the 5-hour and 10-hour, or 15-hour MA training and the Medication Skills Competency Validation checklist completed prior to administering medications if they completed the requirements	D 125		

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D 125	Continued From page 3 with their former employer. -He did not have any documentation from Staff D or Staff E from their former employers for completion of the 5-hour and 10-hour, or 15-hour MA training. -He was not aware all MAs were required to complete a Medication Skills Competency Validation checklist upon new employment. -He was responsible for ensuring all MAs met the eligibility requirements before administering medications. _____ The facility failed to ensure two medication aides, Staff D and Staff E, completed the 5-hour and 10-hour or 15-hour medication aide training and the Medication Skills Competency Validation prior to administering medications placing the residents at risk for medication errors. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/05/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 19, 2026.	D 125		
D 225	10A NCAC 13F .0702 (c) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (c) The facility administrator or their designee shall assure the following requirements for written notice are met before discharging a resident: (1) The Adult Care Home Notice of Discharge	D 225		

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D 225	Continued From page 4 with the Adult Care Home Hearing Request Form shall be completed and hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from theDivision of Health Benefits, on the internet website https://policies.ncdhhs.gov/divisional/healthbenefits-nc-medicaid/forms. The Adult Care Home Notice of Discharge shall include the following: (A) the date of notice; (B) the date of transfer or discharge; (C) the reason for the notice; (D) the name of responsible person or contact person notified; (E) the planned discharge location; (F) the appeal rights; (G) the contact information for the long-term care ombudsman; and (H) the signature and date of the administrator. (2) A copy of the completed Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative and the individual identified upon admission to receive a discharge notice on behalf of the resident on the same day the Adult Care Home Notice of Discharge is dated. For the purposes of this Rule "responsible person" means a person chosen by the resident to act on their behalf to support the resident in decision-making; access to medical, social, or other personal information of the resident; manage financial matters; or receive notifications. The Adult Care Home Hearing Request Form shall include the following: (A) the name of the resident; (B) the name of the facility;	D 225		

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D 225	Continued From page 5 (C) the date of transfer or discharge; (D) the date of scheduled transfer or discharge; (E) the selection of how the hearing is to be conducted; (F) the name of the person requesting the hearing; and (G) for the person requesting the hearing, their relationship to the resident, address, telephone number, their signature, and date of the request. (3) Provide the following material in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the resident and the resident's legal representative and the individual identified upon admission to receive a copy the discharge notice on behalf of the resident: (A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter; (B) a copy of the resident's current physician's orders, including medication order; (4) Failure to use and simultaneously provide the specific forms according to Subparagraphs (c)(1) and (c)(2) of this Rule shall invalidate the discharge. (5) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility administrator or their designee prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record. This Rule is not met as evidenced by:	D 225		

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D 225	Continued From page 6 Based on interviews and record reviews, the facility failed to ensure the requirements for written notice of discharge were met prior to discharging residents ensuring a written discharge notice was hand delivered or sent by certified mail to the responsible party or legal representative for 2 of 4 sampled residents (#10 and #13) prior to discharge. The findings are: Review of the undated facility's Discharge, Transfer and Refunds policy revealed : -The discharge of a resident initiated by the community at the direction of the Executive Director/Administrator or their designee must be based on one of the following: -Discharge was necessary to protect the welfare of the resident and the facility could not meet the needs of the resident as documented by the resident's physician, physician assistant, or nurse practitioner in the resident's record. -The reason for the transfer or discharge of the resident were to include one or more of the following: -Documentation by the resident's physician, physician assistant, or nurse practitioner; the condition or circumstances that endangered the health or safety of the resident, and the facility's action taken to address the problem prior to pursuing discharge of the resident. -The specific health need or condition of the resident that the facility determined could not be met and as disclosed in the Resident contract upon admission. -If the facility decided to discharge a resident who had been transferred to an acute inpatient facility and there had been no physician-documented level of care change for the resident, the discharge requirement then apply.	D 225		

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D 225	Continued From page 7 1. Review of Resident #10's current FL-2 dated 05/27/25 revealed: -Diagnoses included type 2 diabetes mellitus, hypertension, schizophrenia, hyperlipidemia, iron deficiency anemia, and chronic kidney disease stage 4. -Resident #10 was intermittently disoriented. -Resident #10 was ambulatory. -The level of care was domiciliary (rest home). Review of Resident #10's Resident Register revealed: -Resident #10 was admitted to the facility on 10/29/07. -Resident #10's responsible person was a family member. -There was a second family member listed to receive a copy of the discharge notice. -The discharge/transfer information was blank. Review of Resident #10's accident/incident report dated 10/11/25 revealed: -The incident occurred at 7:20am. -Resident #10 stated he lost his balance and fell on the floor. -Resident #10 complained of back and leg pain and was transported to the Emergency Department (ED). Review of Resident #10's hospital discharge summary dated 10/15/25 revealed: -Resident #10 was seen in the ED on 10/11/25 for multiple falls and generalized weakness. -Emergency Medical Services (EMS) reported the Assisted Living (AL) staff stated Resident #10 had redness and swelling of his right foot which was progressively getting worse. -Resident #10 had significant erythema and edema to the right foot extending from the great	D 225		

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toe to the 5th toe to the mid foot with mild tenderness to palpation.
-Resident #10 was diagnosed with lower right extremity cellulitis with an elevated white blood cell count with an infected wound between the fourth and fifth toes on the right foot.
-Resident #10 was admitted to the hospital on 10/11/25 for intravenous antibiotics to treat the cellulitis.
-Resident #10 was discharged on 10/15/25 to a skilled nursing facility (SNF) for rehabilitation.

Telephone interview with Resident #10's family member on 12/05/25 at 3:19pm revealed:
-The family was not notified that Resident #10 had fallen on 10/11/25, was admitted to the hospital on 10/11/25, and discharged to a SNF on 10/15/25.
-The SNF notified the family on 10/17/25 that Resident #10 had been admitted to their facility on 10/15/25, upon discharge from the hospital.
-The family was not issued a discharge notice for Resident #10 by the AL facility.
-She visited the facility on Monday, 10/20/25, and spoke with the Resident Care Coordinator (RCC) and the Administrator.
-She was informed that Resident #10 was discharged from the facility because the facility was on a suspension of admissions and could not accept Resident #10 after the hospitalization until the suspension of admissions was lifted.
-She did not receive any notice through phone, mail, or in person, that Resident #10 had been discharged from the facility.

Interview with the lead medication aide (MA) on 12/05/25 at 11:15am revealed:
-Resident #10 was discharged from the facility because he was admitted to the hospital.
-Resident #10 would be a new admission upon

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return to the facility and the facility could not accept new admissions when Resident #10 was discharged from the hospital.
-She called Resident #10's family member and left a voice mail regarding Resident #10 being admitted to the hospital on 10/11/25.
-She thought the Administrator discharged Resident #10 from the facility.

Interview with the Administrator on 12/05/25 at 2:45pm revealed:
-He discontinued Resident #10's information on the computer.
-He did not realize he discharged Resident #10 from the facility.
-He did not notify the family that Resident #10 was discharged from the facility.
-Resident #10 would be able to come back to the facility once the facility was able to admit residents.
2. Review of Resident #13's FL2 dated 09/16/25 revealed:
-Diagnoses included type 2 diabetes mellitus with hyperglycemia, type 2 diabetes mellitus with diabetic neuropathy, essential hypertension, hyperlipidemia, osteoarthritis, and anxiety.
-The level of care was skilled nursing facility (SNF).

Review of Resident #13's Resident Register revealed:
-Resident #13 was admitted to the facility on 07/24/25.
-The resident's responsible person was documented.
-Resident #13 was discharged to a local hospital on 10/01/25.
-Resident #13's responsible person signed the discharge information on the Resident Register on 10/01/25, but there was no documentation the

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responsible person was given a Notice of Discharge and Right to Appeal documents.

Review of Resident #13's Home Health note dated 09/27/25 revealed:
-Home Health was called to see Resident #13.
-Resident #13 had a leaky catheter leg bag.
-The leaking leg bag was unable to be changed due to the bag requiring a special connector.
-Resident #13 reported to Home Health that he did not have an appointment with urology until the following week.
-Resident #13 was advised he would need to be sent to an Emergency Department (ED).

Review of Resident #13's Nurse Practitioner (NP) notes revealed:
-On 09/09/25, Resident #13 went out due to not voiding and no urine in bag.
-On 09/16/25, Resident #13 was seen by the NP for a follow-up visit for an unwitnessed fall and complaint of shoulder pain.
-On 9/23/2025, Resident #13 was seen by the NP after he went out to a local hospital but came back; his catheter bag was changed in the ED. Resident #13 had outpatient surgery 09/18/25.
-There was documentation of a suprapubic catheter placement on 09/18/25.

Review of Resident #13's facility notes provided by the Administrator on 12/04/25 and 10/05/25 revealed:
-There was no documentation of a 30 day Discharge Notice or Right of Appeal issued to Resident #13 available for review.
-There had been no physician-documented level of care change for the resident, or the reason Resident #13 was to be discharged from the facility.

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D 225	Continued From page 11 Telephone interview with the Administrator on 12/05/25 at 12:37pm revealed: -Resident #13 went to the local hospital because the catheter bag was leaking. -The Resident Care Coordinator (RCC) at the time told the local hospital that the resident could not return to the facility due to the catheter requiring skilled nursing care. -The Administrator contacted the family to let them know that Resident #13 could come back to the facility (no exact date provided), but the responsible person did not want the resident to return. -Therefore, the Administrator did not have to give a discharge notice because it was her (responsible person) decision for Resident #13 not to return to the facility. Telephone interview with Resident #13's responsible person on 12/05/25 at 3:08pm revealed: -Resident #13's catheter bag burst so he had to go to the local hospital. -One of the staff at the facility told Resident #13 that he could not come back to the facility with the catheter because it required a SNF. -The local hospital kept Resident #13 because the facility told the hospital representative Resident #13 could not return to the facility. -The responsible person was not given any type of notice. Telephone interview with a case worker at the local hospital revealed: -Resident #13 was admitted to the hospital ED on 09/27/25 due to a fall. -Resident #13 was treated and was told from the facility that he could not return to the facility. -Resident #13 no longer met assisted living criteria, according to the facility.	D 225		

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D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the	D 259		

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D 259	Continued From page 13 portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an assessment and care plan was updated following a significant change in condition for 1 of 6 sampled residents who had right sided weakness and required 2 to 3 staff assistance for transferring and who was admitted to hospice (#6). The findings are: Review of Resident #6's current FL-2 dated 11/04/25 revealed: -Diagnoses included lack of coordination, gastro-esophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), hypertension, dementia, vitamin D deficiency, and benign prostatic hyperplasia. -Resident #6 was intermittently confused. -Resident #6 was semi-ambulatory. -Resident #6 was incontinent of bowel and bladder. Review of Resident #6's care plan dated 10/17/25 revealed: -He required extensive staff assistance with transfers, bathing, grooming, dressing, and toileting. -He required limited staff assistance with eating. -He required staff supervision with ambulation.	D 259		

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Review of Resident #6's Licensed Health Professional Support (LHPS) evaluation dated 10/21/25 revealed Resident #6 required assistance with transfers.

Review of Resident #6's primary care provider's (PCP) after visit summary dated 11/11/25 revealed:
-Resident #6 was seen today for a follow-up visit from a fall on 11/09/25.
-On exam, Resident #6 had right-sided drooping, right-sided weakness and was unable to raise his right arm.
-Resident #6 was sent to the Emergency Department (ED).

Review of the ED note dated 11/11/25 revealed:
-Staff reported that Resident #6 had right sided weakness and was lethargic.
-Resident #6's PCP wanted Resident #6 to have further evaluation.
-Resident #6's condition was discussed with Resident #6's Power of Attorney (POA).
-The POA stated Resident #6 appeared to be at his baseline.
-Resident #6's POA agreed to send Resident #6 back to the Assisted Living (AL) facility without further interventions.
-Resident #6 was placed on hospice on 11/10/25.

Interview with Resident #6's POA on 12/05/25 at 2:00pm revealed:
-Resident #6 was seen in the ED for stroke-like symptoms.
-The family made the decision not to be aggressive with treatment due to Resident #6's decline and his placement on hospice care the day before.

Interview with a personal care aide (PCA) on

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D 259	Continued From page 15 12/04/25 at 3:00pm revealed: -Resident #6 required 2-to-3-person transfer to the wheelchair. -A week or two before he was discharged, he was bedridden and was being fed by staff in his room. Interview with a medication aide (MA) on 12/02/25 at 5:07pm revealed: -Resident #6 was found on the floor on 11/09/25 and was sent to the ED. -Resident #6 was placed on hospice on 11/10/25 because he was declining. -Resident #6 was a 2-to-3-person transfer, required assistance with maneuvering his wheelchair and needed assistance with feeding. -Resident #6 had right sided weakness on 11/11/25. -Resident #6 was sent back to the ED on 11/11/25 during the PCP's visit on 11/11/25 because of stroke-like symptoms. -When Resident #6 returned from the ED, he required assistance with maneuvering his wheelchair. -Resident #6 eventually needed assistance with feeding. Interview with the lead MA on 12/05/25 at 2:45pm revealed: -She had assumed some of the Resident Care Coordinators (RCC) duties since mid-November 2025, when the previous RCC left. -She did not know the RCC was responsible for updating a care plan following a significant change. -She did not update Resident #6's care plan; the previous RCC was still working at the facility during that time. Interview with the Administrator on 12/05/25 at 3:04pm revealed:	D 259		

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D 259	Continued From page 16 -Resident #6 had a significant change in condition the first week of November 2025. -He instructed the previous RCC to update Resident #6's care plan. -He did not know Resident #6's care plan was not updated. -He expected care plans to be updated with significant change in condition.	D 259		
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: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE A2 VIOLATION. Based on observation, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 7 sampled residents (#10) related to increased confusion and redness and swelling of his right foot. The findings are: Review of Resident #10's current FL-2 dated 05/27/25 revealed: -Diagnoses included type 2 diabetes mellitus, hypertension, schizophrenia, hyperlipidemia, iron deficiency anemia, and chronic kidney disease stage 4.	D 273		

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D 273	Continued From page 17 -Resident #10 was intermittently disoriented. -Resident #10 was ambulatory. Review of Resident #10's care plan dated 06/11/25 revealed: -He required supervision with transfers and ambulation. -He required limited staff assistance with eating and toileting. -He required extensive staff assistance with bathing, dressing, and grooming. Review of Resident #10's Home Health (HH) Registered Nurse (RN) note dated 10/03/25 revealed: -The RN provided wound care to the wound on Resident #10's 5th toe on his right foot. -There was no drainage noted to the 5th toe on the right foot. Review of Resident #10's accident/incident report dated 10/06/25 revealed: -The incident occurred at 2:30pm. -Resident #10 was found sitting on the bathroom floor by the Business Office Manager (BOM), -Resident #10 stated he lost his balance and fell. -Resident #10 was not injured and was not sent to the Emergency Department (ED). Review of Resident #10's accident/incident report dated 10/11/25 revealed: -The incident occurred at 6:23am. -Resident #10 tried to stand up and slipped to the floor. -Resident #10 did not have any injuries and was not taken to the ED. Review of Resident #10's accident/incident report dated 10/11/25 revealed: -The incident occurred at 7:20am.	D 273		

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D 273	Continued From page 18 -Resident #10 stated he lost his balance and fell on the floor. -Resident #10 complained of back and leg pain and was transported to the ED. Review of Resident #10's Emergency Medical Services (EMS) report dated 10/11/25 revealed: -Resident #10 was found lying on his back on his bedroom floor. -Resident #10's right foot was noted to have redness and swelling. -Resident #10 wanted to be transferred to the ED for evaluation. -Resident #10 was transported by EMS to the ED related to multiple falls with general weakness. Review of Resident #10's hospital discharge summary dated 10/15/25 revealed: -Resident #10 was seen in the ED on 10/11/25 for multiple falls and generalized weakness. -EMS reported the Assisted Living (AL) staff stated Resident #10 had redness and swelling of his right foot which was progressively getting worse. -Resident #10 had significant erythema (redness) and edema (swelling) to the right foot extending from the great toe to the 5th toe to the mid foot with mild tenderness to palpation. -Resident #10 was diagnosed with lower right extremity cellulitis with an elevated white blood cell count with an infected wound between the fourth and fifth toes on the right foot. -Resident #10 was admitted to the hospital on 10/11/25 for intravenous antibiotics to treat the cellulitis. -Resident #10 was discharged on 10/15/25 to a skilled nursing facility for rehabilitation. Interview with a personal care aide (PCA) on 12/02/25 at 9:20am revealed:	D 273		

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D 273	Continued From page 19 -Resident #10 had fallen several times in the week of 10/06/25. -She found him on the floor one evening and reported it to the medication aide (MA). -She did not know if an accident/incident report was done or not. -Resident #10 was sent out later in the week because of multiple falls. Interview with the BOM on 12/04/25 at 10:50am revealed: -On 10/06/25, she found Resident #10 on the bathroom floor. -He did not complain of any injuries. -She reported to the MA that she found Resident #10 on the bathroom floor. Interview with a MA on 12/04/25 at 11:13am revealed: -On 10/11/25, she worked third shift. -Resident #10 was found on the floor around 6:30am by the PCA. -She assessed Resident #10; he did not have any injuries. -Resident #10 said he lost his balance and fell; he was confused. -Resident #10 was confused a few days prior to that fall. -Earlier in the week, the PCA told her she found Resident #10's clothes in the toilet. -She reported Resident #10's confusion and putting his clothes in the toilet to the lead MA on 10/08/25 or 10/09/25. Interview with the lead MA on 12/04/25 at 8:25am revealed: -She assisted with Resident Care Coordinator (RCC) duties since the facility did not have a current RCC. -On 10/06/25, the BOM found Resident #10	D 273		

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D 273	Continued From page 20	D 273		

sitting on the bathroom floor; there were no injuries noted.
-On 10/11/25 the third shift PCA found Resident #10 on the floor.
-Resident #10 did not complain of any injuries.
-Resident #10 was not his normal self; he removed his incontinent brief and placed it in the commode.
-Normally, the PCAs would assist Resident #10 with his incontinent brief.
-Resident #10 was not sent to the ED because he was not injured.
-She was not aware that Resident #10's right foot was red and swollen.

Telephone interview with a second MA on 12/04/25 at 11:00am revealed:
-On 10/11/25, she worked first shift.
-The third shift MA reported that Resident #10 was found on the floor around 6:30am that morning and he was not his normal self.
-The third shift MA reported that Resident #10 was confused and had placed his pants and incontinent briefs in the toilet.
-On 10/11/25, around 7:30am, she found Resident #10 on the floor in his bedroom.
-Resident #10 complained of his back and his legs hurting.
-Resident #10 was confused, which was not his normal self.
-She called EMS, who helped get Resident #10 off the floor and he was transported to the ED.
-Resident #10 was discharged from the facility after the hospitalization, and he could not return to the facility because the facility could not admit any residents at that time.

Telephone interview with a MA on 12/05/25 at 8:59am revealed:
-Resident #10's right foot was swollen and red.

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D 273	Continued From page 21 -She had reported that Resident #10's right foot was swollen and red to the previous RCC about a week before he was sent to the hospital. -Resident #10 was seen by the HHRN for a wound between his fourth and fifth toe. -She did not know the last time the HHRN had seen Resident #10 before he went to the hospital. Interview with the lead MA on 12/05/25 at 11:00am revealed: -The HHRN was seeing Resident #10 for a wound on his toes on his right foot. -She thought she heard something about Resident #10's right foot being swollen and red but could not remember when she heard it or who told her. -She did not look at Resident #10's right foot since he was being seen by the HHRN. Interview with the HHRN on 12/05/25 at 2:45pm revealed: -Resident #10 was a diabetic and had a wound between his 4th and 5th toe. -The last day she saw him, (she could not remember when) the wounds were scabbed over. -She did not see any swelling or redness of Resident #10's right foot. -No staff had voiced any concerns to her about Resident #10's right foot being swollen or red when she visited Resident #10. -Resident #10 always answered appropriately when she visited for wound care. Telephone interview with Resident #10's family member on 12/05/25 at 3:19pm revealed: -She visited Resident #10 on 10/17/25 at the skilled rehabilitation center. -Resident #10's right foot was bandaged from his toes to just below his ankle. -Resident #10's right foot was not swollen or red.	D 273		

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D 273	Continued From page 22 -Staff verbalized the wound care nurse was managing Resident #10's wound. Interview with the Administrator on 12/05/25 at 2:45pm revealed: -The RCC should be notified when there was a change in a resident's condition, such as confusion and redness and swelling of the foot. -The RCC should have notified the PCP about changes in condition to the residents. -He was concerned because Resident #10 was admitted to the hospital when the infection could have been treated at the facility had the PCP known about the redness and swelling when the staff saw it. -He expected the staff and RCC to communicate better and notify the PCP timely of any changes with the residents. Attempted telephone interview with Resident #10's PCP on 10/05/25 at 3:00pm was unsuccessful. _____ The facility failed to notify the physician of redness and swelling in a lower extremity of a resident (#10) who became confused, had frequent falls and was hospitalized with an infection and received intravenous antibiotics for four days in the hospital before discharging to a skilled rehabilitation facility. This failure of the facility to provide healthcare referral and follow-up to the resident's provider resulted in substantial risk for physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/05/25. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 4,	D 273		

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D 273	Continued From page 23 2026.	D 273		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 6 residents (#8, #12 and #14) observed during the morning medication pass including errors with a blood pressure medication, a stomach acid reducer, and an anti-anxiety medication (#8), a fluid medication (#14) and an inhaler and a topical cream (#12); and 2 of 5 sampled residents (#3 and #4) for record review including errors with sliding scale insulin (#3) and errors with a stool softener (#4). The findings are: 1. The medication error rate was 12% as evidenced by the observation of 6 errors out of 48 opportunities during the 8:00am medication pass on 12/03/25. a. Review of Resident #12's current FL-2 dated	D 358		

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10/14/25 revealed diagnoses included Alzheimer's disease and hypertension.

Observation of the morning medication pass on 12/03/25 at 8:19am revealed:
-The medication aide (MA) removed Resident #12's multi-dose pack from the medication cart; the multi-dose pack contained 8 pills.
-The MA administered the 8 pills to Resident #12.
-The MA did not administer any other medications to Resident #12.

1. Review of Resident #12's signed physician order dated 11/24/25 revealed there was an order for triamcinolone cream (used to treat dry, itchy skin) topically twice daily.

Review of Resident #12's December 2025 electronic medication administration record (eMAR) for 12/03/25 revealed:
-There was an entry for triamcinolone cream apply topically to affected areas twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation triamcinolone cream was administered at 8:00am on 12/03/25.

Telephone interview with a representative from the facility's contracted pharmacy on 12/03/25 at 10:45am revealed:
-Resident #12 had an order for triamcinolone cream apply topically to affected areas twice daily dated 11/24/25.
-The pharmacy dispensed a 15gm tube of triamcinolone cream on 11/24/25.
-Triamcinolone cream was used to treat dry, itchy skin.

Observation of medication on hand for Resident #12 on 12/03/25 at 9:22am revealed there was a

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half-full tube of triamcinolone cream on the medication cart with a dispensed date and an open date of 11/24/25, available for administration.

Interview with Resident #12 on 12/03/25 at 9:40am reveled:
-She did not receive the cream for her dry skin that morning.
-The staff applied the cream when she took her shower.

Interview with the MA on 12/03/25 at 9:25am revealed:
-She did not apply the cream to Resident #12 during the medication pass.
-She would apply the cream to Resident #12 when she received her shower.
-She was told she could apply the Resident #12's cream during her shower by the corporate Registered Nurse.
-She signed the eMAR that the cream had been administered at 8:00am because that was the scheduled time on the eMAR.

Interview with the Administrator on 12/03/25 at 11:19am revealed:
-If the MA did not apply the medication, then she should not have documented that the cream had been applied.
-He expected the MAs to document on the eMAR after the medications were administered, not before they were administered.

Attempted telephone interview with Resident #12's Primary Care Provider (PCP) on 12/05/25 at 10:15am and 3:00pm were unsuccessful.

2. Review of Resident #12's signed physician orders dated 11/18/25 revealed there was an

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order for albuterol sulfate inhaler 90mcg (used to treat shortness of breath and wheezing) inhale 2 puffs four times daily for chronic obstructive pulmonary disease (COPD).

Review of Resident #12's December 2025 electronic medication administration record (eMAR) from 12/01/25 to 12/03/25 revealed:
-There was an entry for albuterol sulfate 90mcg inhale 2 puffs four times daily with a scheduled administration time of 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was documentation that albuterol sulfate 90mcg was administered at 8:00am on 12/03/25 during the morning medication pass.

Telephone interview with a representative from the facility's contracted pharmacy on 12/03/25 at 10:45am revealed:
-Resident #12 had an order for albuterol inhaler 2 puffs four times daily.
-The pharmacy dispensed an albuterol inhaler on 11/15/25 which contained 200 inhalations.
-The albuterol inhaler was used for shortness of breath or wheezing related to COPD.
-If the albuterol inhaler was administered as ordered, 200 inhalations would last 25 days.

Observation of medication on hand for Resident #12 on 12/03/25 at 9:25am for Resident #12 revealed there was no albuterol inhaler on the medication cart available for administration.

Interview with the MA on 12/03/25 at 9:25am revealed:
-She administered Resident #12's albuterol inhaler after Resident #12 returned to her bedroom; she did not like to administer the inhaler in the hallway.
-Resident #12's inhaler was not on the medication

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cart; it was in the medication room.
-She got Resident #12's inhaler from the medication room and administered the medication.
-She returned the inhaler to the medication room after she administered the inhaler to Resident #12 because she thought the inhaler had expired.

Second observation on the medication on hand for Resident #12 on 12/03/25 at 9:30am revealed:
-There was an albuterol inhaler in the medication room with a dispensed date of 11/15/25; there was no date documented when the inhaler was first used.
-There were 200 of 200 inhalations in the albuterol inhaler remaining that was dispensed on 11/15/25.

Interview with Resident #12 on 12/03/25 at 9:40am revealed:
-She did not receive her albuterol inhaler that morning.
-She did not have any problems with shortness of breath or wheezing.

Interview with the Administrator on 11/04/25 at 11:19am revealed:
-Resident #12's albuterol inhaler should have been on the medication cart and administered as ordered.
-He expected the MAs to administer the medications as ordered.

Attempted telephone interview with Resident #12's Primary Care Provider (PCP) on 12/05/25 at 10:15am and 3:00pm were unsuccessful.

b. Review of Resident #8 current FL-2 dated 11/04/25 revealed diagnoses included dementia without behavior, generalized anxiety disorder,

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and hypertension.

1. Review of Resident #8's signed physician order dated 11/24/25 revealed there was an order for metoprolol succinate extended-release tablet (used to treat elevated heart rate and high blood pressure) 25mg once daily.

According to the Food and Drug Administration (FDA) metoprolol succinate extended-release tablets are scored and can be divided; however, the whole or half tablet should be swallowed whole and not chewed or crushed.

Observations during the morning medication pass on 12/03/25 at 8:45am revealed:
-The medication aide (MA) removed Resident #8's multi-dose package from the medication cart; the multi-dose package contained 8 pills.
-Metoprolol succinate 25mg was included in the 8 tablets contained in the multi-dose package for Resident #8.
-The MA prepared oral medications for administration by punching the medications into a paper souffle cup.
-The MA removed a capsule and one tablet from the paper souffle cup stating the two medications should not be crushed. Metoprolol succinate 25mg was not removed from medications prepared by crushing and added to 2 teaspoonfuls of applesauce.
-The MA added the capsule and tablet that had been previously removed on top of the applesauce mixture and administered the crushed oral medications to Resident #8.
-Resident #8 took her medications with water without difficulty.

Review of Resident #8's December 2025 electronic medication administration record

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(eMAR) for 12/03/25 revealed:
-There was an entry for metoprolol succinate extended release 24-hour 25mg once daily.
-There was documentation metoprolol succinate extended release 24-hour 25mg was administered at 9:00am on 12/03/25.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/03/25 at 12:00pm revealed:
-The pharmacy dispensed routine oral medications for one week supply packaged in multi-dose packages and some medications in individual bingo packages cards for 28- or 30-days' supply.
-Medications that should not be crushed had labeling to indicate do not crush or chew provided the pharmacy was made aware of the facility's needed to crush a resident's medication.
-Resident #8's metoprolol succinate extended release 24-hour 25mg was not labeled for do not crush on the multi-dose package due to the resident not being identified by the facility as a resident requiring crushing of medications prior to administration.

Observation of medication on hand for Resident #8 revealed:
-There was a multi-dose package for Resident #8 labeled Week 1 on the medication cart with morning, midday, evening and bedtime multi-dose bubbles labeled with the date to be administered and medications in the bubble.
-There was a bubble containing 8 medications, including metoprolol succinate 25mg, labeled for administration in the morning on 12/04/25 and medications labeled for administration for midday, evening, and bedtime on 12/04/25 available for administration.
-There were no medications labeled for do not

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D 358	Continued From page 30 crush. Interview with the MA on 12/03/25 at 8:45am revealed: -The contracted pharmacy often indicated on the label of the multi-dose package or the eMAR if a medication should not be crushed. -There was no information for do not crush medications for Resident #8 on the resident's multi-dose packages, individual bubble cards or the eMAR. -She routinely crushed Resident #8's medications and added to applesauce because the resident preferred medications crushed and added to applesauce. -She knew, from the previous facility she was employed , that the two medications she removed before crushing should not be crushed. -She did not remove metoprolol succinate 25mg extended release before crushing because she did not recognize the medication should not be crushed. Interview with Resident #8 on 12/03/25 at 3:50pm revealed: -She had been taking her medications crushed in applesauce because the medications were easier for her to take. -She knew some medications were on top of the applesauce and not crushed but she did not know which one. -She had no problems with her medications. Interview with the Administrator on 12/03/25 at 3:00pm revealed: -The MAs were responsible for administering medications according to the recommendations for each medication. Extended-release tablets should not be crushed. -The Resident Care Coordinator (RCC) was	D 358		

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responsible for auditing eMARs and observation of medication administration for appropriate administration.
-Due to staff turnover of the RCC in November 2025, he was serving as the RCC as well as the Administrator.
-He did not know Resident #8's metoprolol succinate 25mg extended-release tablets were being crushed before administration.

Telephone interview with Resident #8's Primary Care Provider (PCP) on 12/04/25 at 10:30am revealed:
-She recently assumed care for Resident #8.
-She did not recall all of Resident #8's medications.
-Extended-release medications should not be crushed.
-If she was aware a resident required medications to be crushed, she routinely reviewed the medications with the contracted pharmacy and made adjustments to the medication dosage form if a medication could not be crushed.

2. Review of Resident #8's signed physician order dated 11/24/25 revealed there was an order for pantoprazole 20mg delayed release (DR) once daily. (Pantoprazole 20mg DR is used to decrease stomach acid secretion.)

According to Drugs.com (website) pantoprazole delayed release, enteric coated tablets should be swallowed whole and not chewed or crushed to avoid interfere in the release in the intestine.

Observations during the morning medication pass on 12/03/25 at 8:45am revealed:
-The medication aide (MA) removed Resident #8's multi-dose package from the medication cart; the multi-dose package contained 8 pills and

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a bingo card labeled pantoprazole 20mg DR 20mg.
-The MA prepared oral medications for administration by punching the medications from the multi-dose package and one pantoprazole 20mg DR tablet into a paper souffle cup.
-The MA removed a capsule and one tablet from the paper souffle cup stating the two medications should not be crushed. Pantoprazole 20mg DR was not removed from medications prepared by crushing and adding to 2 teaspoonfuls of applesauce.
-Resident #8 took her medications with water without difficulty.

Review of Resident #8's December 2025 eMAR for 12/03/25 revealed:
-There was an entry for pantoprazole 20mg DR tablet once daily.
-There was documentation pantoprazole 20mg DR tablet was administered at 9:00am on 12/03/25.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/03/25 at 12:00pm revealed:
-The pharmacy dispensed routine oral medications for a one week supply packaged in multi-dose packages and some medications in individual bingo packages cards for 28- or 30-days' supply.
-Medications that should not be crushed had labeling on the mutli-dose or individual packages to indicate do not crush or chew provided the pharmacy was made aware of the facility's needed to crush a resident's medication.

Observation of medication on hand for Resident #8 on 12/03/25 at 8:45am revealed:
-There was a bubble card of pantoprazole 20mg

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D 358	Continued From page 33 DR labeled for one tablet daily dispensed fromn the contracted pharmacy on 11/03/25 for 30 tablets of 120 tablets with 24 of 30 tablets remaining. -There was no labeling for do not crush. Interview with the MA on 12/03/25 at 8:45am revealed: -The contracted pharmacy often indicated on the label of the multi-dose package, bubble card, or the eMAR if a medication should not be crushed. -There was no information for do not crush medications for Resident #8 on the resident's multi-dose packages, individual bubble cards or the eMAR. -She routinely crushed Resident #8's medications and added to applesauce because the resident preferred medications crushed and added to applesauce. -She knew from the previous facility she was employed that the two medications she removed before crushing should not be crushed. -She did not remove pantoprazole 20mg DR before crushing because she did not recognize the medication should not be crushed. Interview with Resident #8 on 12/03/25 at 3:50pm revealed: -She had been taking her medications crushed in applesauce because the medications were easier for her to take. -She knew some medications were on top of the applesauce and not crushed but she did not know which one. -She had no problems with her medications. Interview with the Administrator on 12/03/25 at 3:00pm revealed: -The MAs were responsible for administering medications according to the recommendations	D 358		

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for each medication.
-Delayed-release tablets should not be crushed.
-The Resident Care Coordinator (RCC) was responsible for auditing eMARs and observation of medication administration for appropriate administration.
-Due to staff turnover of the RCC in November 2025, he was serving as the RCC as well as the Administrator.
-He did not know Resident #8's pantoprazole 20mg DR tablets were being crushed before administration.

Telephone interview with Resident #8's PCP on 12/04/25 at 10:30am revealed:
-She recently assumed care for Resident #8 (early November 2025).
-She did not recall all Resident #8's medications.
-Extended-release medications should not be crushed.
-If she was aware a resident required medications to be crushed, she routinely reviewed the medications with the contracted pharmacy and made adjustments to the medication dosage form if a medication could not be crushed.

c. Review of Resident #14's current FL-2 dated 06/23/25 revealed diagnoses including heart failure and hypertension.

Review of Resident #14's signed physician orders dated 06/23/25 and 10/31/25 revealed an order for furosemide 80mg (used to treat high blood pressure and fluid buildup from heart failure) once daily.

Review of Resident #14's physician's order dated 11/18/25 revealed an order for furosemide 80mg twice a day.

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D 358	Continued From page 35 Review of Resident #14's subsequent physician's order dated 12/01/25 revealed: -There were new diagnoses including hypotension (low blood pressure). -The resident's blood pressure was 90/67 documented on the physician's order. -There was an order to discontinue 3 medications for hypertension. -There was an order to decrease furosemide to 80mg daily. Observation of medication administration on 12/03/25 at 8:10am revealed: -Resident #14 came to the medication cart for his medications but asked if he could go to the adjacent sitting room due to being a bit dizzy. -The MA prepared and administered Resident #14's oral medications and a nasal spray. -The MA took the medications to an adjacent sitting area and administered the medications with water. -Furosemide 80mg was not administered to Resident #14. Review of Resident #14's December 2025 from 12/01/25 to 12/03/25 eMAR revealed: -There was an entry for furosemide 80mg twice a day scheduled for administration at 9:00am and 2:00pm. -There was documentation furosemide 80mg was not administered (marked by an X in the field for documentation) on 12/02/25 at 9:00am and 2:00pm and on 12/03/25 at 9:00am. -There was no entry for furosemide 80mg once daily. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/3/25 at 12:00pm revealed: -The contracted pharmacy received Resident	D 358		

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D 358	Continued From page 36 #14's order to discontinue furosemide 80mg twice a day dated 12/01/25. -The contracted pharmacy entered the order for furosemide 80mg once daily scheduled for 9:00am onto the eMAR. -Orders entered by the contracted pharmacy onto the eMAR must be reviewed and accepted by the facility's approved staff for the medication to appear on the eMAR for staff to administer. -If furosemide 80mg daily was not showing up on the eMAR for Resident #14, then the order needed to be approved and accepted in order for the order to start appearing on the eMAR. -The contracted pharmacy maintained a medication profile and generated the resident's eMAR based on physician's orders received by the contracted pharmacy. Interview with the morning medication aide (MA) on 12/03/25 at 12:00pm revealed: -Resident #14 did not have an active order for furosemide 80mg listed on his eMAR. -She administered medications according to the eMAR. -She did not have access to new orders for residents, that was the responsibility of the Resident Care Coordinator (RCC) or the Administrator. -The RCC or Administrator reviewed orders and approved the orders in order for a resident's medication order to appear on the eMAR for administration. -Resident #14 had no furosemide 80mg available to administer. Observation of medication on hand for Resident #14 on 12/03/25 at 3:30pm revealed there was no furosemide 80mg available for administration on the medication cart.	D 358		

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D 358	Continued From page 37 Interview with the Administrator on 12/03/25 at 3:00pm revealed: -The RCC was responsible for auditing eMARs and observation of medication administration for appropriate administration. -Due to staff turnover of the RCC in November 2025, he was serving as the RCC as well as the Administrator. -He was responsible for reviewing and accepting orders entered by the contracted pharmacy prior to the orders appearing on the eMAR for administration. -He had not accepted and release the orders for Resident #14 from 12/01/25 or 12/02/25: therefore, the furosemide was not showing on the eMAR for administration on 12/02/25. Interview with Resident #14 on 12/03/25 at 3:54pm revealed: -He had been experiencing dizziness, lightheadedness, and low blood pressure for a couple of weeks. -He saw his PCP on 12/01/25 and several of his medications were discontinued. -He thought he remembered the PCP said she was going to decrease his fluid pill (furosemide) to once daily. -He did not check his medications when he was administered the medications, so he did not know if he had received his fluid pill. -He was a little dizzy during the medication pass this morning, so he asked to have his medications brought to the adjacent sitting room where he could sit to keep from falling. -He had been urinating regularly. -He had been weighing himself daily and he had no fluid weight gain in the last 3 days. Telephone interview with Resident #14's PCP on 12/04/25 at 10:30am revealed:	D 358		

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D 358	Continued From page 38 -She recently assumed care for residents of the facility in early November 2025, including Resident #14. -She did not recall all Resident #14's medications. -She reviewed and approved all orders for residents she followed in the facility. -If she approved Resident #14's orders on 12/02/25, she expected the facility to administer medications the next day. 2. Review of Resident #3's current FL-2 dated 06/30/25 revealed: -Diagnoses included development disabilities and diabetes Mellitus. -There was an order for Novolog Flexpen 100units/ml (a synthetic insulin for control of elevated blood sugar) inject per sliding scale 3 times a day. Information posted on the web by the American Diabetes Association (ADA) emphasized the importance of blood sugar control in diabetes management, highlighting its role in preventing complications and improving overall health outcomes for diabetics. Complications included damage to major oragns like the eyes and the kidneys. Review of Resident #3's physician's orders dated 03/10/25 and 10/30/25 revealed an order for Novolog Flexpen U-100 sliding scale insulin (SSI) inject subcutaneously as directed per scale 3 times daily before meals: 0-200=0 units (U); 201-250= 2U; 251-300= 4U; 301-350= 6U; 351-400= 8U; 401-450= 10U; 451-500= 12U; greater than 500 plus go to ED (emergency department) and notify MD (medical doctor). Review of Resident #3's physician orders dated 03/11/25 and 10/30/25 revealed and order for	D 358		

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finger stick blood sugar (FSBS) before meals and at bedtime- If blood sugar (BS) less than 100 give 9 ounces of orange juice and recheck in 15 minutes.

Review of Resident #3's October 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Novolog Flexpen U-100 SSI inject subcutaneously as directed per scale 3 times daily before meals: 0-200=0 units (U); 201-250= 2U; 251-300= 4U; 301-350= 6U; 351-400= 8U; 401-450= 10U; 451-500= 12U; greater than 500 plus go to ED and notify MD scheduled for administration at 7:00am, 11:30am, and 5:00pm.
-The range for 8:00am FSBS values documented was 139 to 215.
-The range for 11:30am FSBS values documented was 108 to 219.
-The range for 5:00pm FSBS values documented was 117 to 266.
-There were 8 of 19 opportunities for the SSI administration from 10/01/25 to 10/31/25 when Novolog Flexpen SSI was not administered as ordered.
-Examples of Novolog Flexpen U-100 not administered according to SSI parameter for FSBS values included:
-On 10/16/25 at 7:00am, FSBS value =206; there should have been 2 units administered but 0 units were documented as administered.
-On 10/14/25 at 7:00am, FSBS value =215; there should have been 2 units administered but 0 units were documented as administered.
-On 10/03/25 at 11:30am, FSBS value =219; there should have been 2 units administered but 0 units were documented as administered.
-On 10/02/25 at 5:00pm, FSBS value =216; there should have been 2 units administered but 0 units

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	HAL073018	A. BUILDING: _____ B. WING _____	R-C 12/05/2025

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THE CANTERBURY HOUSE	1284 LEASBURG ROAD ROXBORO, NC 27573

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were documented as administered.
-On 10/26/25 at 5:00pm, FSBS value =202; there should have been 2 units administered but 0 units were documented as administered.

Review of Resident #3's November 2025 eMAR revealed:
-There was an entry for Novolog Flexpen U-100 SSI inject subcutaneously as directed per scale 3 times daily before meals: 0-200=0 units (U); 201-250= 2U; 251-300= 4U; 301-350= 6U; 351-400= 8U; 401-450= 10U; 451-500= 12U; greater than 500 plus go to ED and notify MD scheduled for administration at 7:00am, 11:30am, and 5:00pm.
-The range for 8:00am FSBS values documented was 131 to 226.
-The range for 11:30am FSBS values documented was 136 to 297.
-The range for 5:00pm FSBS values documented was 117 to 291.
-There was 1 of 24 opportunities for the SSI administration from 11/01/25 to 11/30/25 when Novolog Flexpen SSI was not administered as ordered.
-Novolog Flexpen U-100 was not administered according to SSI parameter for FSBS values on 11/18/25 at 11:30am, the FSBS value =227; there should have been 2 units administered but 0 units were documented as administered.

Interview with the lead medication aide (MA) on 12/04/25 at 10:15am revealed:
-She had been the MA who documented FSBS values for Resident #3 on most of the days when Novolog Flexpen U-100 SSI units were not documented.
-She knew Resident #3 had Novolog Flexpen U-100 insulin ordered according to SSI parameters.

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D 358	Continued From page 41 -She did not know why the amount of SSI Novolog Flexpen U-100 was not documented on the eMARs. -She felt certain that she administered the Novolog Flexpen U-100 insulin as ordered. -She was not responsible for auditing the residents' eMARs for accuracy or completeness. Interview with the Administrator on 12/03/25 at 3:00pm revealed: -The MAs were responsible for administering medications according to the current orders for each medication. -The Resident Care Coordinator (RCC) was responsible for auditing eMARs and observation of medication administration for appropriate administration. -Due to staff turnover of the RCC in November 2025, he was serving as the RCC as well as the Administrator. Interview with the Administrator on 12/05/25 at 3:00pm revealed: -In the absence of a current RCC due to current staff shortages, he was responsible for auditing residents' eMARs for medication administration including completeness of documentation. -He currently did not have a system in place for routinely auditing residents' eMAR. -A corporate nurse had been performing random record audits in the absence of the RCC, however he was not sure what the nurse was auditing. -He did not know Resident #3 had SSI Novolog Flexpen U-100 errors in administration on the eMARs. -The former RCC should have seen the errors in October 2025 eMAR if she had been auditing the eMARs.	D 358		

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D 358	Continued From page 42 Attempted interview with Resident #12's Primary Care Provider (PCP) on 12/05/25 at 10:15am and 3:00pm was unsuccessful. Based on observations, interviews, and record review it was determined Resident #3 was not interviewable. 3. Review of Resident #4's current FL-2 dated 06/11/25 revealed diagnoses included major depressive disorder, congestive heart disease (CHF), and atrial fibrillation. Review of Resident #4's signed physician orders dated 06/20/25 revealed there was an order for polyethylene glycol 17 gram/dose mix one capful in 8 ounces of fluid daily, hold for loose stools. Review of Resident #4's signed physician orders dated 11/18/25 revealed there was an order for polyethylene glycol 17 gram/dose mix one capful in 8 ounces of fluid daily, hold for loose stools. Review of Resident #4's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for polyethylene glycol 17 gram/dose mix one capful in 8 ounces of fluid daily, hold for loose stools, with a scheduled administration time of 8:00am. -There was documentation that polyethylene glycol 17gm was administered daily from 10/01/25 to 10/31/25. Review of Resident #4's November 2025 eMAR revealed: -There was an entry for polyethylene glycol 17 gram/dose mix one capful in 8 ounces of fluid daily, hold for loose stools, with a scheduled administration time of 8:00am.	D 358		

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D 358	Continued From page 43 -There was documentation that polyethylene glycol 17gm was administered daily from 11/01/25 to 11/30/25. Review of Resident #4's December 2025 eMAR from 12/01/25 to 12/03/25 revealed: -There was an entry for polyethylene glycol 17 gram/dose mix one capful in 8 ounces of fluid daily, hold for loose stools, with a scheduled administration time of 8:00am. -There was documentation that polyethylene glycol 17gm was administered daily from 12/01/25 to 12/03/25. Observation of medication on hand for Resident #4 on 12/03/25 at 2:00pm revealed: -There was a 510gm bottle of polyethylene glycol dispensed on 10/14/25, with an opened dated of 10/26/25 on the medication cart and available for administration. -The bottle of polyethylene glycol was ¼ full. Telephone interview with a representative from the facility's contracted pharmacy on 12/03/25 at 10:45am revealed: -Resident #4 had an order for polyethylene glycol 17gms daily with the most current order dated 11/18/25 and the previous order dated 06/20/25. -The pharmacy dispensed a 510gm bottle of polyethylene glycol on 08/05/25, 10/14/25, and 12/03/25. -A 510gm bottle of polyethylene glycol would last 30 days if administered as ordered. -If the bottle was opened on 10/26/25, then a new bottle should have started on 11/26/25. -Polyethylene glycol was not on cycle fill; the staff would have to re-order the medications when it was needed. -Polyethylene glycol was used for constipation. -Resident #10 could have increased constipation.	D 358		

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D 358	Continued From page 44 Interview with Resident #4 on 12/05/25 at 11:56am revealed: -He received his medications. -He did not know if there was a medication mixed in his water or not. -He took the medications the medication aide (MA) gave him. -He did not have any problems with constipation. Interview with a personal care aide (PCA) on 12/05/25 at 10:45am revealed Resident #4 did not complain of constipation. Interview with a MA on 12/05/25 at 8:59am revealed: -She administered Resident #4's polyethylene each morning she worked. -She did not know a bottle of polyethylene would only last 30 days. -The bottle on polyethylene glycol was opened on 10/26/25; that bottle should be empty. -It appeared someone was not administering the medication as ordered. -Resident #4 had not complained of constipation to her. Interview with the lead MA on 12/05/25 at 11:00am revealed: -Resident #4 took polyethylene glycol for constipation. -Resident #4 did not refuse his polyethylene glycol. -Resident #4 was dispensed a 510gm bottle which would last 30 days. -If Resident #4's bottle of polyethylene glycol was opened on 10/26/25, then a new bottle should have started on 11/26/25. -If there was medication in the bottle opened on 10/26/25, Resident #4 was not being	D 358		

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D 358	Continued From page 45 administered his polyethylene glycol daily as ordered. Telephone interview with Resident #4's Primary Care Provider (PCP) on 12/05/25 at 10:35am revealed: -Resident #4 was ordered polyethylene glycol 17gms daily for constipation. -The staff had not notified her of any constipation problems with Resident #4. Interview with the Administrator on 11/04/25 at 11:19am revealed: -He expected the MAs to administer the medications as administered. -The bottle of medication should only last a month and should have been completed a week ago. _____ The facility failed to ensure medications were administered as ordered to residents observed during the 8:00am medication pass on 12/03/25 related to a resident who did not receive a topical steroid cream for itching which placed the resident at risk for un-necessary discomfort, and an albuterol inhaler for improved breathing placing the resident at risk for shortness of breath and labored breathing(#12); a resident who had 2 extended release medications, metoprolol succinate for elevated blood pressure and heart rate and pantoprazole for increase gastric acid, that were crushed placing the resident at risk for failure of medication therapy related to blood pressure control and indigestion discomfort (#8); a resident that did not receive furosemide 80 mg for control of blood pressure and fluid placing the resident at risk for elevated blood pressure and fluid build up (#14); and a resident not receiving the correct doses of sliding scale insulin for diabetes control placing the resident at risk for uncontrolled blood sugar levels which can	D 358		

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D 358	Continued From page 46 damage the kidneys and the eyes (#3). This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/04/25. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 19, 2026.	D 358		
D 430	10A NCAC 13F .1106 (d) Settlement Of Cost Of Care 10A NCAC 13F .1106 Settlement Of Cost Of Care (d) When a resident gives notice of leaving the facility, as may be required by the facility according to Rule .0702(i) of this Subchapter, and leaves at the end of the notice period, the facility shall refund the resident the remainder of any advance payment within 14 days from the date of notice. If notice is not required by the facility, the refund shall be made within 14 days after the resident leaves the facility. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 1 sampled resident (#11) who left the facility was refunded the remainder of payment 14 days after leaving the facility.	D 430		

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D 430	Continued From page 47 The findings are: Review of the facility's undated Discharge, Transfer and Refunds policy revealed the facility would refund any monies paid for the cost of services and care from the date of discharge or transfer through the end of the month of discharge or transfer, and the refund would be issued within 14 days from the date of discharge or transfer. Review Resident #11's current FL-2 dated 10/08/25 revealed: -The resident had diagnoses including hypertension, muscle weakness, unspecified cerebrovascular, anxiety disorder, and unspecified abnormalities of gait and mobility. -The discharge plan indicated skilled nursing facility. Review of Resident #11's Resident Register revealed: -The resident was admitted to the facility on 10/27/22 and transferred to another facility on 10/10/25. -Resident #11 had a family member who was the resident's responsible person. Interview with the Business Office Manager (BOM) on 12/03/25 at 2:25pm revealed: -The BOM emailed the facility's corporate office about the refund on 12/03/25 and was told that the refund was in process. -The BOM had not contacted the resident's responsible party because she did not know the date of the refund. Interview with Resident #11's responsible person on 12/03/25 at 2:52 pm revealed: -Resident #11 had not received a refund; she	D 430		

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D 430	Continued From page 48	D 430		

spoke with the BOM who was responsible to do the admittance and discharge entry onto the census on 10/07/25, 10/08/25, or 10/09/25 (not sure which day).
-She received a telephone call from the Administrator and the Nurse Practitioner (NP) late in the morning on 10/03/25.
-During the telephone call, the Administrator and NP notified her that Resident #11 needed to leave the facility for a different level of care, and she was told she had to find a place for Resident #11.
-On 10/10/25 between 9:00am and 10:00 am, she left the facility with Resident #11.
-Resident #11's check for her room and board went into the account on 10/03/25 and she left on 10/10/25.
-She requested a refund from the BOM and was told that she was within the timeframe of a refund since it had only been 7 days.
-The facility sent her a bill for the exact amount that she was supposed to get refunded.
-She and Resident #11 were supposed to receive a conference call from the Administrator and NP, but that never happened.

Interview with the BOM on 12/04/25 at 9:19am revealed:
-The 30-day notice was initiated in September.
-There was a level of care change and she was not made aware of the discharge.
-The BOM was aware that the refund was past the 14 days requirement.
-Resident #11 was discharged from the facility's census system, then corporate took over from there.
-Corporate was responsible to process the refund.
-The BOM emailed corporate yesterday (12/03/25) and was told they sent the refund

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D 430	Continued From page 49 yesterday. Interview with the Administrator on 12/04/25 at 9:38am revealed: -The Administrator was unaware that Resident #11 needed a refund for her money until yesterday (12/03/25) when he was asked for the facility's refund policy. -Resident #11's check would be mailed today (12/04/25). -The resident's responsible person should have the refund check by Saturday, 12/06/25. Attempted telephone interview with a corporate accounts payable representative on 12/04/25 at 10:11am was unsuccessful.	D 430		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the local county Department of Social Services (DSS) of an accident/incident that required emergency medication evaluation for 1 of 2 sampled residents (#10) who had a fall.	D 451		

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D 451	Continued From page 50 The findings are: Review of Resident #10's current FL-2 dated 05/27/25 revealed: -Diagnoses included type 2 diabetes mellitus, hypertension, schizophrenia, hyperlipidemia, iron deficiency anemia, and chronic kidney disease stage 4. -Resident #10 was intermittently disoriented. -Resident #10 was ambulatory. Review of Resident #10's accident/incident report dated 10/11/25 revealed: -The incident occurred at 7:20am. -Resident #10 stated he lost his balance and fell on the floor. -Resident #10 complained of back and leg pain and was transported to the Emergency Department (ED). Telephone interview with a medication aide (MA) on 12/04/25 at 11:00am revealed: -On 10/11/25, around 7:30am, she found Resident #10 on the floor in his bedroom. -Resident #10 complained of his back and his legs hurting. -Resident #10 was confused, which was not his normal self. -She called Emergency Medical Services (EMS), who helped get Resident #10 off the floor and he was transported to the ED. -The lead MA completed the accident/incident report. Interview with the lead MA on 12/05/25 at 11:00am revealed: -She completed the incident report for Resident #10 on 10/11/25. -She did not send the accident/incident report to	D 451		

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D 451	Continued From page 51 the Adult Home Specialist (AHS) at the Department of Social Services (DSS). -She did not know the accident/incident report for a fall when the resident was sent to the ED needed to be sent to the AHS. Interview with the AHS on 12/05/25 at 12:20pm revealed: -She did not receive Resident #10's accident/incident report dated 10/11/25 for a fall and emergency care was needed. -The facility should send all accident/incident reports that require emergency care by email or fax within 24 to 48 hours. Interview with the lead MA on 12/05/25 at 11:00am revealed she verbally told the Administrator when there was an accident/incident report in the computer system that needed to be reviewed. Interview with the AHS on 12/05/25 at 12:20pm revealed the accident/incident reports were sent to her supervisor by email and her supervisor forwarded the accident/incident reports to her. Interview with the Administrator on 12/05/25 at 3:30pm revealed: -He knew the accident/incident reports had to be sent to the AHS. -He was sending the accident/incident reports to the wrong email address.	D 451		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a	D 454		

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D 454	Continued From page 52 resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the responsible party for 1 of 2 sampled residents (#10) who had multiple falls and required emergency evaluation related to a fall. The findings Review of Resident #10's current FL-2 dated 05/27/25 revealed: -Diagnoses included type 2 diabetes mellitus, hypertension, schizophrenia, hyperlipidemia, iron	D 454		

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D 454	Continued From page 53	D 454		

deficiency anemia, and chronic kidney disease stage 4.
-Resident #10 was intermittently disoriented.
-Resident #10 was ambulatory.

Review of Resident #10's accident/incident report dated 10/11/25 revealed:
-The incident occurred at 7:20am.
-Resident #10 stated he lost his balance and fell on the floor.
-Resident #10 complained of back and leg pain and was transported to the ED.

Review of a text message dated 09/27/25 at 3:30pm between Resident #10's responsible person and the previous Resident Care Coordinator (RCC) revealed the responsible person's new telephone contact number was texted to the RCC.

Telephone interview with Resident #10's responsible person on 12/05/25 at 3:19pm revealed:
-The responsible person was not notified of Resident #10's fall and hospital admission on 10/11/25.
-The responsible person was notified on 10/17/25 from the skilled nursing facility (SNF) that Resident #10 was admitted on 10/17/25, upon discharge from the hospital.
-The responsible person's phone number was changed in September 2025.
-She called the facility and spoke to the previous RCC on 09/27/25.
-The RCC asked if she would text the phone number to her because she was currently busy.
-She texted the new phone number to the previous RCC on 09/27/25.

Interview with the lead medication aide (MA) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073018	A. BUILDING: _____ B. WING _____	R-C 12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CANTERBURY HOUSE	1284 LEASBURG ROAD ROXBORO, NC 27573

(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 454	Continued From page 54 12/05/25 at 11:00am revealed: -She did not speak to Resident #10's responsible person regarding the accident/incident report on 10/11/25. -She left a message on the previous phone number. -She did not know Resident #10's responsible person's phone number had been changed. -The phone number had not been updated in Resident #10's record. Interview with the Administrator on 12/05/25 at 2:45pm revealed: -He did not know that Resident #10's family was not contacted regarding the fall and hospitalization on 10/11/25. -The staff documented on the accident/incident report that Resident #10's responsible person had been notified of the fall and hospitalization. -He was notified on 12/03/25 by the surveyor that the telephone number the facility had for Resident #10's responsible person was a non-working phone number. -He expected the staff to update new information when it was reported.	D 454		