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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN SPRING LIVING CENTER	3812 BOOKER STREET DURHAM, NC 27713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an Annual survey on 01/06/26 to 01/07/26.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure referral and follow-up to meet health care needs for 1 of 1 sampled residents (#1) who had a physician's order for a nutritional supplement. The findings are: Review of Resident #1's current FL2 dated 11/19/25 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD) and chronic kidney disease (CKD). -He was semi-ambulatory. Review of Resident #1's Resident Register revealed he was admitted to the facility on 11/17/25. Review of Resident #1's physician orders dated 11/19/25 revealed there was an order for a magic cup dessert supplement during lunch. Review of Resident #1's medications on hand on 01/06/26 at 2:26pm revealed there were no supplements available.	D 273		

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D 273	Continued From page 1 Interview with Resident #1 on 01/07/26 at 8:02am revealed: -He received the supplement when he was in the hospital. -Staff told him that he had to pay for the supplement out of pocket. -He was not going to pay for the supplement because he did not need it. Interview with a medication aide (MA) on 01/07/26 at 8:25am revealed: -She aware Resident #1 had an order for a supplement and had not received it. -She contacted the pharmacy to order the supplement. -The pharmacy stated the supplement was not covered under insurance and the resident would be responsible for the cost. -Resident #1 stated he was not paying for the supplement because he did not need it that badly. Interview with the Administrator on 01/07/26 at 11:12am revealed: -He was aware Resident #1 was not receiving the supplement. -The pharmacy said the supplement was not covered under Resident #1's insurance; the resident would have to pay out of pocket. -Resident #1 refused to pay for the supplement. -The primary care provider (PCP) was not notified that the resident refused to pay for the supplement. Attempted telephone interview with Resident #1's PCP on 01/06/26 at 10:54am was unsuccessful.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support	D 280		

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D 280	Continued From page 2 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the assessment and evaluation by a licensed health professional for 1 of 3 sampled residents (#1) who had an order for oxygen. The findings are: Review of Resident #1's current FL2 dated 11/19/25 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD) and chronic kidney disease (CKD).	D 280		

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D 280	Continued From page 3 -He was semi-ambulatory. Review of Resident #1's Resident Register revealed he was admitted to the facility on 11/17/25. Review of Resident #1's resident record revealed: -There was no licensed health professional support (LHPS) evaluation available to review. -There was an order for oxygen 4 liters as needed. Observation of Resident #1's room on 01/06/26 at 8:26am revealed: -There was an oxygen concentrator which supplied oxygen at 4 liters per minute via nasal cannula to Resident #1. -There was a portable oxygen tank and a portable oxygen concentrator. Interview with Resident #1 on 01/07/26 at 8:02am revealed he used oxygen when he was in his room. Telephone interview with the LHPS nurse on 01/06/26 at 2:00pm revealed: -She was responsible for completing LHPS evaluations. -The facility would call her when there was a new admission. -She had not completed LHPS evaluations since 10/07/25. Interview with the Administrator on 01/07/26 at 11:12am revealed: -He was responsible for ensuring LHPS evaluations were completed. -There was a facility nurse consultant he used to complete LHPS evaluations on all residents. -He was not aware that Resident #1's LHPS	D 280		

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D 280	Continued From page 4 evaluation had not been completed. -It was an oversight; he forgot to contact the nurse. Attempted telephone interview with Resident #1's primary care provider (PCP) on 01/06/26 at 10:54am was unsuccessful.	D 280		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure all food items stored and prepared by the facility were served under sanitary conditions related to expired food and a food container that was not properly labeled. The findings are:	D 282		

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D 282	Continued From page 5 Review of the Environmental Health Services inspection report dated 11/14/25 revealed: -The kitchen sanitation score was 91.5. -There was a 3-point deduction received under protection from contamination; food separated and protected. -There was a 1.0-point deduction received under chemical; toxic substances properly identified stored and used. -There was a 0.5-point deduction received under food temperature control; approving thawing methods used. -There was a 1.0-point deduction received under utensils and equipment; equipment, food and non-food contact surfaces approved, cleanable, properly designed, constructed and used. -There was a 1.0-point deduction received under physical facilities; meets ventilation and lighting requirements; designated areas used. Observation of the facility's refrigerator on 01/06/26 at 9:16am revealed: -There was an open and undated container of potato salad. -There was an open container of expired vegetable soup dated 12/28/25. Telephone interview with the Environmental Health Specialist (EHS) from the Local Department of Environmental Health on 01/06/26 at 1:46pm revealed: -She last visited the facility on 11/14/25. -She cited the facility for a dented can of tuna, packages were not protected from contamination, and improperly thawing food. -All opened foods should have been labeled using the month, day, and year to ensure it was discarded within seven days. Interview with a cook on 01/06/26 at 9:21am	D 282		

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D 282	Continued From page 6 revealed: -She was responsible for labeling foods in the refrigerator. -She did not realize the container had not been dated. -She checked the refrigerator daily for expired foods. -She did not see the expired vegetable soup because it was in the back of the refrigerator. Interview with the Administrator on 01/06/26 at 9:49am revealed: -The cook was responsible for overseeing the kitchen environment. -He was not aware there was undated and expired food in the refrigerator. -He expected the cook to ensure food was properly stored in the refrigerator.	D 282		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#3) including a medication used to prevent constipation.	D 358		

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D 358	Continued From page 7 The findings are: Review of Resident #3's current FL-2 dated 12/18/25 revealed diagnoses included coronary artery disease, peripheral neuropathy, degeneration of lumbar or lumbosacral intervertebral disc, and degeneration of cervical intervertebral disc. Review of Resident #3's physician orders dated 12/18/25 revealed an order for Linzess (a medication used to treat constipation) 125mcg, take one capsule by mouth every day with a meal. Review of Resident #3's electronic medication administration record (eMAR) for November 2025 revealed Linzess was documented as administered daily from 11/01/25 through 11/30/25. Review of Resident #3's eMAR for December 2025 revealed Linzess was documented as administered daily from 12/01/25 through 12/31/25. Review of Resident #3's eMAR for January 2026 from 01/01/26 through 01/07/26 revealed Linzess was documented as administrated daily from 01/01/26 through 01/07/26. Observation of medications on hand for Resident #3 on 01/06/26 at 9:33am revealed there was one bottle of Linzess with a dispensed date of 11/14/25 with 30 out of 30 remaining Telephone interview with a representative from the facility's contracted pharmacy on 01/07/26 at 9:39am revealed: -Linzess was used to treat constipation.	D 358		

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-Resident #3 had a current order for Linzess 125mcg.
-The pharmacy dispensed a 30-day supply of Linzess for Resident #3 on 09/10/25, 10/12/25 and 11/14/25.
-Linzess was not on a medication cycle, and the facility must request to refill it.
-They did not receive any requests to refill Linzess since 11/14/25.

Interview with Resident #3 on 01/07/26 at 9:10am revealed:
-He was not sure what medications he took each day.
-He did not have symptoms of constipation.
-He could not remember the last time he had been constipated.

Interview with the Supervisor-in-Charge (SIC) on 01/07/26 at 11:10am revealed:
-She was not aware that Resident #3 was not receiving Linzess as ordered.
-The pharmacy did medication cart audits, but she could not recall how often.
-The medication aides (MA) should do cart audits weekly and look for expired medications, medications with no current order, and discontinued medications.
-There was no documentation the MAs were completing the medication cart audits.

Interview with the Administrator on 01/07/26 at 11:25am revealed:
-He was not aware that Resident #3 was not getting the Linzess as ordered.
-The pharmacy did medication cart audits quarterly, auditing for medications on hand, how medications are being stored, and correct dates.
-The MA ' s were expected to audit the carts weekly, checking for medications that need to be

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D 358	Continued From page 9 reordered from the pharmacy, and medications on hand. -He did not require the MAs to keep track of the cart audits. -He expected the MA's to administer the Linzess as ordered.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the	D 367		

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electronic medication administration record (eMAR) was accurate for 1 of 3 residents (#3) related to a medication for blood pressure.

The findings are:

Review of Resident #3's current FL-2 dated 12/18/25 revealed diagnoses included coronary artery disease, peripheral neuropathy, degeneration of lumbar or lumbosacral intervertebral disc, and degeneration of cervical intervertebral disc.

Review of Resident #3's physician orders dated 12/18/25 revealed an order for amlodipine (a medication used to treat high blood pressure) 10mg, take 1 tablet by mouth daily.

Review of Resident #3's record revealed a handwritten order dated 12/18/25 to decrease the amlodipine from 10mg to 5mg due to his blood pressure running low.

Review of Resident #3's eMAR for December 2025 revealed:
-There was an entry for amlodipine 10mg daily scheduled at 8:00am.
-Amlodipine 10mg was documented as administered daily from 12/01/25 through 12/31/25.
-There was a second entry for amlodipine, take 5 mg daily scheduled at 8:00am with a start date of 12/19/25.
-Amlodipine 5mg was documented as administered daily from 12/19/25 through 12/31/25.

Review of Resident #3's eMAR for January 2026 from 01/01/26 through 01/07/26 revealed:
-There was an entry for amlodipine 10mg daily

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scheduled at 8:00am.
-Amlodipine 10mg was documented as administered daily from 01/01/26-01/07/26.
-There was an entry for amlodipine 5mg daily scheduled at 8:00am.
-Amlodipine 5mg was documented as administered daily from 01/01/26-01/07/26.

Observation of medications on hand for Resident #3 on 01/07/26 at 8:50am revealed:
-There was one full blister pack of amlodipine 5mg with a dispense date of 01/06/26 and 31 of 31 dispensed tablets remaining.
-There was no amlodipine 10mg on hand.

Telephone Interview with a representative from the facility's contracted pharmacy on 01/07/26 at 9:39am revealed:
-Resident #3's amlodipine 10mg was last dispensed on 11/25/25 and then discontinued on 12/18/25.
-The amlodipine 5mg order was received on 12/18/25 and dispensed on 12/18/25 and 01/06/25 with a quantity of 31 tablets each dispense date.
-The pharmacy was responsible for entering and discontinuing all orders on the eMAR.
-The pharmacy mistakenly did not remove amlodipine 10mg from the eMAR when it was discontinued by the primary care provider (PCP).
-The facility did not contact the pharmacy to request amlodipine 10mg be removed from the eMAR?

Telephone interview with a nurse from Resident #3's PCP's office on 01/07/26 at 10:22am revealed:
-Resident #3 was ordered amlodipine to treat high blood pressure.
-The PCP decreased the amlodipine dose from

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10mg daily to 5mg daily on 12/18/25 because Resident #3's blood pressure was running too low.
-If Resident #3 received both doses of amlodipine, his blood pressure could have become very low.
- She expected the medication aides (MAs) to administer the amlodipine as ordered by the PCP.

Interview with the Supervisor-in-Charge on 01/07/26 at 11:10am revealed:
-She did not realize the amlodipine 10mg was left on the eMAR after it had been discontinued.
-The pharmacy was responsible for entering all orders onto the eMAR.
-She was not sure why she documented that the amlodipine 10mg was administered but could be from just clicking off medications on the eMAR too fast.
-The MAs and SIC should have called the pharmacy to ask why the amlodipine 10mg was not sent and then they would have found the error.
-All MAs were responsible for making sure any orders entered on the eMAR were correct.
-There was no tracking system in place for new orders.

Interview with the Executive Director (ED) on 01/07/26 at 11:25am revealed:
-He was not aware that the amlodipine 10mg was left on the eMAR after it was discontinued.
-The pharmacy was responsible for entering all orders onto the eMAR and then sent a confirmation fax to the facility.
-The MAs were responsible for comparing the confirmation fax to the eMAR before approving it to be entered on the eMAR for administration.
-The facility had no new order tracking system in place.

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D 367	Continued From page 13 -He expected the MAs to keep track of new orders to make sure they were being entered onto the eMAR correctly.	D 367		