	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL053028	B. WING	<del></del>	l l	R / <b>16/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
DOYAL O	AVE ASSISTED LIVING	1107 CA	RTHAGE STREET				
ROYAL O	AKS ASSISTED LIVING	SANFOR	RD, NC 27350				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 000	Initial Comments		D 000				
	annual survey and a	sure Section conducted an follow-up survey on August elephone exit on August 16,					
D 074	10A NCAC 13F .0306 Furnishings	6(a)(1) Housekeeping And	D 074				
	10A NCAC 13F .0306 Furnishings (a) Adult care homes (1) have walls, ceilin coverings kept clean	s shall: gs, and floors or floor					
	failed to maintain floo carpets, toilets, show clean and in good rep	as evidenced by: ns and interviews, the facility ors, walls, ceiling vents, er curtains and doorways pair for residents' rooms f7 and #10) and bathrooms.					
	The findings are:						
	room #1 revealed: -There was browned doorway with frayed of from the floorThere were dried yet and back wallThere were numerous sized black markings	edges and had separated  llow liquid stains on the left  us 2-inch patches of pinhead on the walls at the ceiling on the wall 8 inches above					

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

(X6) DATE TITLE

DIVISION	n Health Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
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		HAL053028	D. WING	<del></del>	08/1	6/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1107 CAR	THAGE STREE	т		
ROYAL O	AKS ASSISTED LIVING		D, NC 27350	•		
			7, NC 27330	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 074	Continued From page	e 1	D 074			
	Observation on 08/14	./19 at 9:45 am of the				
	bathroom in resident					
		build-up of brown dust and				
	•	he room and at the base of				
	the doorframe.	ne room and at the base of				
		ains on the baseboard.				
		nd brown stains on the				
	linoleum flooring.					
		nudge marks on the walls.				
		nd yellow stains on the toilet				
	base under the seat.					
	•	plack and brown stains on				
	the floor around the b					
	-The metal toilet pape	er holder was coated with				
	rust.					
	-There was a heavy of	coating of fuzzy gray dust on				
	the ceiling vent.					
		at 10:12 am with a resident				
	in room #1 revealed:					
	-The facility had been	treated for bed bugs last				
	month, but there were	e still smears on the walls				
	from the spray and he	eat treatments.				
	-No staff washed the	walls or painted over the				
	smears and stains on	the walls.				
	Observation on 08/14	/19 at 10:36 am of resident				
	room #7 revealed:					
	-There was browned	stained carpet at the				
		edges and was separated				
	from the floor.	<u> </u>				
	-There was a 2-inch h	by 2-inch patch of pinhead				
		on the wall above the				
	bathroom door.	2.1.2.1.2.1.2.1.2.2.2.2.2.2.2.2.2.2.2.2				
	Datin Com Goor.					
	Interview on 08/14/10	at 9:55 am with a resident				
		hey had never seen their				
	bathroom being clean	iea.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMP	LETED
		HAL053028	B. WING		I	R / <b>16/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DOYAL O	AKO ACCIOTED I IVINO	1107 CAR	THAGE STREE	Т		
ROYAL O	AKS ASSISTED LIVING	SANFORE	), NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 074	Continued From page	2	D 074			
	Observation on 08/14 room #10 revealed th	./19 at 10:38 am of resident ere was browned stained with frayed edges and was				
	bathroom in resident -There was a heavy be dirt in the corners of the doorframeThere were brown st -The base of the shown a white and yellow filt -There were yellow at linoleum flooringThere was a large grunder the toilet and ir -The linoleum flooring detached and curling -There were black spr sinkThere was a 6-inch we floor between the toilet	avilid-up of brown dust and the room and at the base of ains on the baseboard. Wer curtain was coated with m. Indicate the sink on the room. If under the sink was above the floor. Becks on the wall under the wide puddle of water on the et and the sink. Indicate the sink was above the floor.				
	in room #10 revealed -The resident bathroo the toilets were clean often)The frayed carpet on could be a trip hazard Interview on 08/15/19 Housekeeper reveale -He started working a worked one day a we (PCA) and four days	om floors were mopped, and ed (would not say how the floor at the room's door l.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL053028	B. WING		R 08/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
ROYAL OAKS ASSISTED LIVING			RTHAGE STREE	т	
NOTAL OF	AND ADDIOTED EIVING	SANFOR	D, NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 074	Continued From page	e 3	D 074		
	with cleaning the facili-He vacuumed the rethe residents' bathrood disinfectant for the state He replaced the toile the residents' bathroothad to use a hand-he floors.  He did not dust or cleaning He was not aware the #10 had a water leak repair.  He had not noticed as	lity. sidents' rooms and cleaned oms daily using bleach and ains. et paper and paper towels in oms. spin when running, so he eld vacuum to clean the ean the bathroom air vents. e bathroom in resident room and the flooring needed any live bed bugs or bed bug ts' rooms' walls, he did not			
	to clean the facility ar -She expected staff to room, bathroom, and mattresses weekly. -Bathroom baseboard not have a build-up o -She expected neede her; there was mainte work within 24 hours. -She tried to do a wal	ekeeper and the PCA staff and residents' rooms. To deep clean each residents' wipe down residents' and corner areas should f dirt. The defender of the depairs to be reported to the depairs to do the defender of the defende			
D 234	Medical Exam & Imm		D 234		
	10A NCAC 13F .0703 Examination & Immu	3 Tuberculosis Test, Medical nizations			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		-	A. BUILDING: _			
		HAL053028	B. WING		08/10	6/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING	1107 CAR	THAGE STREE	т		
NO IAL O	AND ADDIOTED EIVING	SANFORD	, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 234	Continued From page	: 4	D 234			
	resident shall be tested in compliance with the by the Commission for specified in 10A NCA subsequent amendmenthe rule are available the Department of He Tuberculosis Control					
	This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 1 of 3 sampled residents (Resident #2) was tested for tuberculosis (TB) disease upon admission.					
	The findings are:					
	Review of Resident #2's current FL-2 dated 08/06/19 revealed diagnoses included bi-polar disorder, anemia, history of left wrist fracture and acute kidney injury.					
	Review of Resident # revealed an admissio					
	skin test completed or result on 07/12/18. -There was no docum	2's record revealed: tation the resident had a TB n 07/09/18 with a negative tentation the resident had a ompleted upon admission.				
	#2 revealed:	at 3:45 pm with Resident				

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being admitted to the facility.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
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		HAL053028	B. WING		08/1	6/2019
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TO UNE OF TH	TO VIDER OIL OUT FEILIN					
ROYAL O	AKS ASSISTED LIVING		THAGE STREE	ı		
		SANFOR	D, NC 27350			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
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TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
D 234	Continued From page	5	D 234			
2 -0 .	Continued From page		5 = 5 .			
	-She did not know she	e needed to have a second				
	TB skin test.					
	-No one spoke to her	about having a second TB				
		ince she had been admitted.				
	Interview on 08/16/19	at 9:04 am with the				
		inator (RCC) revealed:				
		ave a TB skin test completed				
		•				
	prior to admission to t	•				
		completed 2 to 3 weeks later.				
		esident #2 did not have				
	documentation in her	records for a second TB				
	skin test.					
	-She was responsible	for assuring residents				
	completed TB skin tes	sting documentation in their				
	records.					
	-She audited resident	s' records last week and did				
	not realize that Resid					
	second TB skin test.	one we did not have a				
	Scoona 1D Skin tost.					
	Interview on 08/16/19	at 0:11 am with the				
	Administrator reveale					
		esident #2 did not have two				
	completed TB skin tes					
		ave a TB skin test before				
	admission and a seco	ond TB skin test completed				
	30 days later.					
	-Residents' records w	vere audited weekly by the				
	Administrator and the					
	-Documentation of co	mpleted TB skin tests "fell				
	under the radar", it wa					
D 276	10A NCAC 13F .0902	2(c)(3-4) Health Care	D 276			
	404 NOAC 40E 0000	)      <del>  </del>				
	10A NCAC 13F .0902					
	· ·	ssure documentation of the				
	following in the reside					
	(3) written procedures	s, treatments or orders from				
	a physician or other li	censed health professional;				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		HAL053028	B. WING		08/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ΓΕ, ZIP CODE	
DOVAL O	AVE ACCIETED I IVING	1107 CAR	THAGE STREE	г	
ROYALO	AKS ASSISTED LIVING	SANFORD	, NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 276	Continued From page	e 6	D 276		
	and (4) implementation of	procedures, treatments or abparagraph (c)(3) of this			
	reviews, the facility fa orders were implement	ns, interviews, and record iled to assure physician nted for 1 of 5 sampled ders for portable oxygen and			
	dated 02/26/19 revea	1's current hospital FL2 led diagnoses included ulmonary disease (COPD), ailure to thrive.			
	dated 06/11/19 reveal -Resident #1 had an of used when he was in -Resident #1 reported when he removed his -Resident #1 reported consistently between of the facility at medic -Resident #1 had a di prescribed oxygen at	Patient Encounter report led: bxygen concentrator that he his room. I his oxygen level dropped oxygen. I his oxygen saturation is 85 and 87 when he was out			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		R	
		HAL053028	B. WING		08/16/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		HAGE STREE	т		
	OLIMAN DV OT		, NC 27350	PROVIDEDIO DI AN OF CORDECTIO	N	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 276	Continued From page	<del>2</del> 7	D 276			
	facility before having -Resident #1's oxyger while at rest was 94% -After walking the lengapproximately 3 minus aturation was 85% a -There was an order to used at 2L via nasal of throughout the day or revealed Resident #1 oxygen in place when dining hall and on the Interview with Reside	to stop to rest. In saturation on room air Is with a pulse of 70. Igh of the facility, after Ites, Resident #1's oxygen Ind his pulse was 93. If portable oxygen to be canula.  Item #1 at various times In 08/14/19 and 08/15/19 Item id did not have portable In he was in the hallways, Item outside of the facility.				
	Interview with Resident #1 on 08/14/19 at 9:34 am revealed: -He had physician's orders for continuous oxygenHe did not have portable oxygen tanks to take with him when he left his roomWhen he ambulated outside of his room, he had to stop to catch his breathHe sometimes needed to walk to the store without any oxygen.					
	at 12:45 pm revealed -The facility staff knew oxygen, but they had	v he needed portable				
	provider on 08/15/19 -Resident #1 was last -He required oxygen to the did not have portal	t seen in April 2019. at his visit in April 2019, but ble oxygen. In trying to obtain oxygen				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
		HAL053028	B. WING		0.5	R 8/ <b>16/2019</b>
NAME OF R	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIR CODE	1 00	710/2013
TWAME OF T	NOVIDEN ON OUT FIELD		RTHAGE STREET	, Zii OODL		
ROYAL O	AKS ASSISTED LIVING		RD, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	3:30 pm revealed: -She ordered portable June 2019 due to his breath when ambulat -She did not know Re portable oxygen at th -She would have exp ordered the portable oxydered the portable oxydered the portable oxydent #1 should the comportable oxygen" (portable oxygen was Resident #1He had not seen Resident Residen	ily activities.  Int #1's PCP on 08/15/19 at  e oxygen for Resident #1 in report of shortness of ing outside of his room. esident #1 did not have e facility. ected for the facility to have oxygen by now.  cation Aide (MA) on revealed: have oxygen on all the time.				
	-He had never seen F difficulty with breathin stop to catch his breat Interview with the Res (RCC) on 08/15/19 at -She was responsible reports for changes a -She knew about the portable oxygen for R -She was responsible equipment and thoug oxygen for Resident # -Resident #1 did not coxygen available at the	Resident #1 having any any and had not seen him the while ambulating.  sident Care Coordinator 4:19 pm revealed: for reviewing physician and new orders. physician's order for resident #1. for ordering medical the she had ordered portable #1 about 2 weeks ago. currently have portable				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		HAL053028	B. WING		08/16/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		HAGE STREE	Т		
	CLIMMADV CT	SANFORD,		DROVIDEDIS DI AN OF CORDECTIO	N are	
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D 276	Continued From page	9	D 276			
	oxygen for Resident # -Portable oxygen had					
	02/26/19 revealed the	t #1's current FL2 dated ere was a physician's order rital signs 2 times monthly th.				
	Review of Resident #1's electronic Medication Administratoin Record (eMAR) for July 2019 revealed:  -There was an entry for vital signs: blood pressure (BP), pulse, and temperature and vital signs were to be taken twice monthly on the 1st and 15th.  -There was no documentation of vital signs for 07/01/19 and 07/15/19.					
	revealed: -There was an entry f pressure (BP), pulse, signs were to be take and 15th.	1's eMAR for August 2019 for vital signs: blood and temperature and vital in twice monthly on the 1st mentation of vital signs for				
	for Resident #1 revea -There was no docum 07/01/19 and 07/15/1 -It was documented "I 08/01/19.	nentation of BP taken on 9. Resident Refused" on				
	pm revealed:	nt #1 on 08/15/19 at 3:03 is vital signs twice a month.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL053028	B. WING		08	R 3/ <b>16/2019</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		RTHAGE STREET			
	1	SANFOR	RD, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 276	-He did not know how supposed to be check since staff checked the staff weighed him so check his vital signs and did not have his July, or August 2019.  Interview with Reside Physician (PCP) on Crevealed: -She wrote an order #1's vital signs to be resident being admin medicationShe signed physicial vital signs to be checked twice a more did not know Renot been checked sir -She expected for Rechecked twice a more checked twice a more checked twice a more checked twice a more sident's vital signs included the had not seen any resident's vital signs once a monthHe did not know if the for Resident #1's vital signs once a monthHe did not know if the for Resident #1's vital signs once a month.	w often his vital signs were ked, but it had been a while nem. Ometimes, but they did not including his BP. have his vital signs checked vital signs checked in June, on the state of the side of the	D 276			

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
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		HAL053028	B. WING		08/1	16/2019
					,	,
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADL	RESS, CITY, STA	ATE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING	1107 CART	HAGE STREE	ET .		
1101712 07		SANFORD	, NC 27350			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
D 276	Continued From page	s 11	D 276			
D 210	Continued From page	; II	D 210			
	Interview with the Res	sident Care Coordinator				
	(RCC) on 08/15/19 at	4:19 pm revealed:				
		ers to have his vital signs				
	checked twice a mon					
		** **				
		Resident #1's vital signs had				
		month and should have				
	been documented on	the eMAR.				
		to have his vital signs				
	checked at times, but					
	-She did not documer	nt she notified Resident #1's				
	PCP when he refused	d to have his vital signs				
	checked.					
	Interview with the Adr	ministrator on 08/15/19 at				
	4:20 pm revealed:					
	•	s (MAs) were responsible				
		s' vital signs including BP,				
	_					
	pulse and temperatur					
		order to check vital signs				
	twice a month on the					
		al signs were last checked				
	for Resident #1 on 06					
	-She expected for Re	sident #1's vital signs to be				
	checked as ordered b	y the physician.				
	A second interview wi	ith the RCC on 08/15/19 at				
	4:46 pm revealed:					
	-	le for checking residents'				
	vital signs.	<b>3</b>				
	-MAs and the RCC w	ere responsible for				
		any issues regarding vital				
	-	arry 1990C9 regarding vital				
	signs.	#11a vital aigna ware to be				
		#1's vital signs were to be				
		th, but she did not know				
	-	ns had not been checked				
	since 06/15/19.					
	-She was responsible	for completing eMAR				

audits.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		HAL053028	B. WING		1	6/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		HAGE STREE	т		
	OUNDAMEN OF		, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 276	Continued From page	: 12	D 276			
	-She had completed e since she started wor	eMAR audits only once king in July 2019.				
D 310	10A NCAC 13F .0904 Service	(e)(4) Nutrition and Food	D 310			
	<ul><li>(e) Therapeutic Diets</li><li>(4) All therapeutic die supplements and thic</li></ul>	Nutrition and Food Service in Adult Care Homes: ets, including nutritional kened liquids, shall be the resident's physician.				
	This Rule is not met a TYPE B VIOLATION	as evidenced by:				
	diets were served as residents with diet ord	failed to assure therapeutic ordered for 2 of 5 sampled lers for a mechanical soft thick liquids (Resident #4)				
	The findings are:					
	02/26/19 revealed: -Diagnoses included I obstructive pulmonary benign prostatic hype reflux disease, constitution B deficiency.	/ disease, hyperlipidemia, rplasia, gastroesophageal				
	Review of Resident # 06/11/19 revealed an	4's physician's orders dated order for a MS diet.				
	Review of the therape	eutic diet list posted in the				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		HAL053028	B. WING		R 08/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ROYAL O	AKS ASSISTED LIVING	1107 CART	HAGE STREE	т	
		SANFORD,	NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 310	Continued From page	2 13	D 310		
	kitchen on 08/14/19 revealed: -Resident #4 was to be served a MS dietNo residents were listed to be served thickened liquids.				
	am revealed: -There was an opene thickener with a phare -The thickener was di	d 36 ounce container of a macy label for Resident #4. spensed by the pharmacy ructions to add as directed to			
	lunch meal on 08/14// -There was a diet lab- indicated ground beer mashed potatoes, bal margarine, brownie, a servedThere was a diet lab- indicated ground beer zucchini, dinner roll si	eled, L3/Advanced, which f brisket, gravy, garlic ked zucchini, dinner roll, and coffee or tea were to be eled, L2/Mech Alt, which f brisket, soft mashed lurry, margarine, brownie ea were to be served.			
	revealed: -He had only worked months and was train -Resident #4 was ser -There were no reside for thickened liquidsHe had seen the conhad not been instruction Resident #4The current menu was because they shared	ved a mechanical soft diet. ents with physician's orders stainer of thickener, but he ed to serve it in liquids for as at the sister facility menus. acility this morning to find			

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<u>Division c</u>	Division of Health Service Regulation					
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
	l				l R	<b>.</b>
	l	HAL053028	B. WING		1	6/2019
		HALU93020			00/1	0/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BOVAL O	AKS ASSISTED LIVING	1107 CAR	THAGE STREE	т		
RUIALOA	4V2 W22I2IED FIAII4G	SANFORE	D, NC 27350			
(X4) ID		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 310	Continued From page		D 310			
			1			
	-He did not know if the	ere was a therapeutic menu.				
	Observation of the lunch meal on 08/14/19					
		nd 12:50 pm revealed:				
		other residents ate their	1			
		adjacent to and opened up	1			ı
	to the main dining hal					
		rved chopped hamburger				
	with gravy, mashed p					
		ch pudding, water and fruit	1			ı
	punch without thicken	chopped hamburger into	1			ı
	smaller portions befor	- · ·				
		d at 12:18 pm after taking a	1			ı
	bite of mashed potato		1			ı
		d at 12:37 pm after taking a	1			ı
	bite of chopped hamb					
		d at 12:38 pm after drinking				
		ut 50% of his meal and had	1			ı
	some drooling as he a		1			ı
		n direct observation of	1			ı
	Resident #4 as he ate	e his meal.				
		::I. II				
		rith the cook on 08/14/19 at				1
	12:40 pm revealed:	nerapeutic menu which	1			ı
		resident who was on a	1			ı
	special diet was to be		1			
		eats for Resident #4 and for	1			ı
		re to be served a MS diet.	1			ı
		nim Resident #4 had any				1
	issues with eating his	meals.				I
	-He and the Personal	l Care Aides (PCAs) walked				I
	around the dining half	I to check on residents				I
	during meals.					I
	Review of the facility's lunch meal on 08/14/	s diet spreadsheet for the 19 revealed:				

-There was a diet labeled "L3/Advanced" which

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
		HAL053028	B. WING		08/16/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING	1107 CART	HAGE STREE	т		
NO IAL O	ARO AGGIOTED EIVIRG	SANFORD,	NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPL	LETE
D 310	Continued From page	e 15	D 310			
	indicated ground pork slice of bread, stewed to be served.  -There was a diet labe indicated pureed pork bread slurry, stewed a be served.  -There was not a diet  Observation of the lur between 12:07 pm and Resident #4 was ser chopped egg roll, teatant 12:15pm, a PCA to said to him "Let me guif we can grind your for At 12:18pm, the PCA chopped deli ham, a stewed apples.	a and veggie stir fry, rice, 1 d apples, coffee or tea were eled "L2/Mech Alt" which a stir fry white rice, 1 slice of apples, coffee or tea were to specifically labeled MS.  The meal on 08/15/19 and 12:35 pm revealed: wed chopped pork stir fry, a and water without thickener. ook Resident #4's plate and tet you another plate and see bod better." A served Resident #4 slice of bread, veggies, and difficulties consuming the tead, veggies, stewed				
	revealed: -The PCAs usually medining hall during measured-she had not noticed eating, coughing, or co-she took Resident #because his food hadd-she did not know who was and did not know served thickened liquid Interview with a second am and 12:20 pm rev	anyone having difficulty with shoking. 4's plate back to the kitchen to be ground. Leat Resident #4's diet order of if Resident #4 was to be ids.  Ind cook on 08/15/19 at 7:45 ealed:				
	was trained by a cook	e facility for 3 months and cat the sister facility. eadsheet to prepare meals				

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DIVISION	n Health Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	D
					R	
		HAL053028	B. WING		08/16/2	2019
		TIALUSSUZU			1 00/10/2	2013
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DOVAL O	AND ACCIDITED I IVINO	1107 CAR	THAGE STREE	т		
ROTAL OF	AKS ASSISTED LIVING	SANFORI	D, NC 27350			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				BEHOLEKOTY		
D 310	Continued From page 16		D 310			
	for residents.					
	-There were 3 resider	nts on MS diets.				
	-He was not sure if he	e should be following the				
	"L3/Advanced" menu	or the "L2/Mech Alt" menu.				
	-He had never asked	anyone or spoken to the				
	facility contracted Reg	gistered Dietician regarding				
	which diet menu to us	se.				
	-He usually just chopp	ped the meats up with a				
		and other residents who had				
	orders for a MS diet.					
		plate for Resident #4 for the				
		19 because the PCA told				
	him Resident 4's mea					
		nd meats for residents on a				
	mechanical soft diet v					
		esidents on thickened				
	liquids since he had v					
		been served thickened				
	liquids.	CAs manitared the dining				
	hall during meal time.	CAs monitored the dining				
	•	or been told anyone had				
	difficulty eating.	been told arryone had				
	amounty canning.					
	Interview with the Hor	me Health provider on				
		esident #4 received speech				
		02/20/19 through 04/08/19,				
	but no other informati	on could be provided.				
	Interview with Reside	nt #4 on 08/15/19 at 11:43				
	am revealed:					
		diet, but it was changed to				
		ysician (not the primary care				
		ods were not giving him				
	enough strength.					
		teeth and sometimes had				
	trouble swallowing.					
		he lunch meal on 08/14/19				
	due to having trouble	swallowing the chopped				

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hamburger.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		HAL053028	B. WING		R 08/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
DOYAL O	ALCO ACCIOTED I IVINO	1107 CAR	THAGE STREE	т	
ROYAL O	AKS ASSISTED LIVING	SANFORD	, NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 310	10 Continued From page 17		D 310		
2 0.10	-He wished the chopp "cut up a little more."	oed hamburger had been kened liquids because he	2 0.0		
	(RCC) on 08/15/19 at -The Administrator wa the therapeutic diet lis served as orderedShe did not know for was onWith MS diets, the mas possibleThere was a blender stopped working on T	as responsible for updating st and ensuring diets were sure which diet Resident #4 leat should be cut up as fine in the kitchen, but it fuesday, 08/13/19. The were any residents in the			
	5:15 pm and on 08/16 -She knew Resident # with eating his meals -She did not know Re served a MS meal wit orderedShe had spoken with wrote an order to star	ministrator on 08/15/19 at 6/19 at 9:18 am revealed: #4 had been having difficulty as served. #5/19 at 9:18 am revealed: #4 had been having difficulty as served. #5/19 at 9:18 am revealed: #4 was not being the thickened liquids as an Resident #4's PCP who at Resident #4 on a pureed the to make a visit with him.			
	8:56 am and 11:52 ar -Resident #4 should be liquids. -She wrote an order of be added as directed Resident #4 due to di -She also wrote an or evaluate and treat Re	on 02/07/19 for thickener to for all beverages for fficulty with swallowing. der for speech therapy to			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7.1.1.2 . 1.2.1.1.1		is a control of the c	A. BUILDING: _			
		HAL053028	B. WING		R 08/16/201	9
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING	1107 CAR	THAGE STREE	т		
		SANFORD	, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COM	X5) IPLETE ATE
D 310	Continued From page	e 18	D 310			
	to be on, but she did served chopped mean difficulty swallowing a during meals.  -She would need to e would write an order of temporarily place Reswith thickened liquids -Not serving the approximate Resident #4 choking and A second Interview w 08/16/19 at 9:18 am right -The Administrator and for completing record to ensure correct order had not made it throut yet.  -The kitchen staff and (MA's) were responsi	rot know he was being trather than ground, having at times, and was coughing valuate Resident #4 and on 08/15/19 for the facility to sident #4 on a pureed diet until she saw him. opriate diet could result in and aspirating.  with the Administrator on revealed: and the RCC were responsible audits (4-5 records) weekly ers were in place, but they gh every resident's record the Medication Aides ble for making sure diets ed and PCA's assisted in				
		vith the facility's contracted on 08/16/19 at 10:37 am				
	02/26/19 revealed: -Diagnoses included failure to thrive.	t #1's current FL2 dated vitamin D deficiency and for nutritional supplements 3 s.				
		eutic diet menu on 08/14/19 was listed as having orders ement.				
	Observation of the res	frigerator on 08/14/19 at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL053028	B. WING		00	R 8/ <b>16/2019</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ROYAL C	AKS ASSISTED LIVING		RTHAGE STREET RD, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 310	-There were 8 carton availableNone of the cartons names.  Review of Resident # Administration Record August 2019 revealed nutritional supplement administration of nutritional supplement according to the were 2 residents on a Resident #1 was sessupplement administration of the lu 08/14/19 between 12 revealed Resident #7 supplement with his supplement with his linterview with Reside am revealed: -He was supposed to supplements with his getting themHe had not had a nuleast 1 monthHe had not asked st supplement and staff they used to.  Interview with a second more revealed:	were labeled with residents'  #1's Medication rd (MAR) for June, July, and d there was no entry for nts and no documentation of ritional supplements.  #2 on 08/14/19 at 11:15 am  #3 cook who trained him there nutritional supplements.  #4 on no entry for no entry fo	D 310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED		
		HAL053028	B. WING		08	R 08/16/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·		
BOYAL O	AKS ASSISTED LIVING	1107 CAI	RTHAGE STREET				
RUYAL O	AKS ASSISTED LIVING	SANFOR	D, NC 27350				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 310	page = t		D 310				
	nutritional supplemen -The Administrator wanutritional supplemen	sident #1 had an order for a ts 3 times daily with meals. as responsible for ordering ts for residents. tritional supplements to					
	8:56 am revealed: -Resident #1 should to supplements 3 times she wrote the order for she thought Resident provider wrote the order expression of the she with the	nowed adequate protein  ous disease provider					
	provider on 08/15/19 not see where the pro nutritional supplemen	nt #1's infectious disease at 1:45 pm revealed she did ovider wrote an order for ts or any mention of ts in Resident #1's medical					
	5:15 pm and 08/16/19 -She was responsible supplementsShe thought only 1 re supplements and did orders for nutritional section -She did not know if Figetting his nutritional	Resident #1 had been supplements as ordered. nts should be documented					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.1.1		15211111101111011152111	A. BUILDING: _			
		HAL053028	B. WING		R 08/16/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		HAGE STREE	Т		
	OLIMAN DV OT	SANFORD,		DDOWNERIO DI ANI OF CORRECTIO		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 310	Continued From page	21	D 310			
	-She did not know there was no documentation of nutritional supplements on eMAR.					
	and thick liquids as or choking and aspiratin Resident #1, with a difailure to thrive, a nutrical day as ordered placing in protein levels. This the health and safety constitutes a Type B. The facility provided a accordance with G.S.	agnosis of a diagnosis of ritional supplement 3 times a g him at risk for a decrease s failure was detrimental to of the residents and Violation.				
	this violation.  CORRECTION DATE VIOLATION SHALL N 2019.	FOR THE TYPE B NOT EXCEED OCTOBER 1,				
D 358	10A NCAC 13F .1004 Administration	e(a) Medication	D 358			
	(a) An adult care hon preparation and admi prescription and nonby staff are in accorda (1) orders by a licens which are maintained	Medication Administration ne shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		R
		HAL053028	B. WING		08/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
ROYAL O	AKS ASSISTED LIVING	1107 CAF	THAGE STREE	т	
			D, NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	22	D 358		
	reviews, the facility fa were administered as prescribing practitione residents (#1 and #2) medications, 2 anti-hy anticholinergic medica	ns, interviews, and record iled to assure medications ordered by a licensed			
	The findings are:				
	02/26/19 revealed dia bloodborne infectious obstructive pulmonary				
	02/26/19 revealed an 1 tablet daily. (Tivicay	t #1's current FL2 dated order for Tivicay 50 mg take is an antiretroviral eat bloodborne infectious			
	Administration Record revealed: -There was an entry f scheduled at 8:00 am -Tivicay was not document.	1's electronic Medication d (eMAR) for July 2019 for Tivicay 50 mg daily i. imented as administered tion) ON ORDER FROM			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE S		
ANDILANC	O CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _	A. BUILDING:		
		HAL053028	B. WING		08/1	6/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ROYAL OA	AKS ASSISTED LIVING	1107 CAR	THAGE STREE	т		
NOTAL OF	AND ADDIOTED EIVING	SANFORE	), NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICE DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358	Continued From page	23	D 358			
D 358	PHARMACY" on 07/2 -Tivicay was not docudue to "NOT ON CAR 07/31/19 at 8:00 amThere were 3 doses  Observation of Reside hand on 08/15/19 at 1 were 30 tablets of Tiv 07/01/19 with 14 table for administration.  Interview with a reprecontracted pharmacy revealed: -The pharmacy did no 02/26/19 for Resident The pharmacy received dated 02/14/19 for Resident The pharmacy through the opharmacy through	29/19 at 8:00 am. Imented as administered RT" on 07/30/19 and of Tivicay 50 mg missed.  In the second of the secon	D 358			
	other staff.	vicay already ordered by nt #1 on 08/15/19 at 12:45				

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		HAL053028	B. WING		08/1	6/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		THAGE STREE	т		
			D, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 24	D 358			
D 358	pm revealed: -He did not get 3 days July 2019When he did not get of July 2019, the MA were at the facility, bu 2019 cycle, and they 2019He felt increased pai not receive his infective the end of July 2019He did not feel the st staff.  Interview with Reside (PCP) on 08/15/19 at -She was not aware t administered for a tot 07/30/19, and 07/31/2 -She was concerned administered as order prescribed for an infe -She did not prescribed -Tivicay was prescribed -Tivicay was prescribed -Tivicay was on 06/11/19 Interview with the Reside (RCC) on 08/15/19 at not know why Reside as ordered on 07/29/2	his medication at the end of told him the medications at the end told him the medications at they were for the August would not be given in July and scared when he did ous disease medications at aff communicated with other are the scale of 3 doses on 07/29/19, 19. That Tivicay was not all of 3 doses on 07/29/19, 19. That Tivicay was not red because it was ctious disease. Tivicay for Resident #1. The scale of the scale	D 398			
	am was unsuccessful  Refer to interview with contracted pharmacy	n a representative from the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HAL053028		B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
ROYAL O	AKS ASSISTED LIVING		RTHAGE STREE RD, NC 27350	т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Refer to interview with 08/15/19 at 4:20 pm at Refer to interview with 4:46 pm and 08/16/19 Refer to interview with 08/16/19 at 11:20 am.  b. Review of Resident 02/26/19 revealed an take 1 tablet daily. (Primedication used to tradiseases).  Review of Resident # Administration Record revealed:  -There was an entry firming daily scheduled at Prezcobix was not do due to "MED (medication used to "MED (medication used to "MED (medication used to "MED (medication used to "NOT ON CAR").  -Prezcobix was not do due to "NOT ON CAR". There were 2 doses and missed.  Observation of Reside hand on 08/15/19 at 10 of Prezcobix 800 mg-	a the MA on 08/15/19 at the Administrator on and 08/16/19 at 12:40 pm.  The RCC on 08/15/19 at the at 12:30 pm.  The second MA on the second M	D 358		
	Interview with a repre contracted pharmacy revealed:	sentative from the on 08/15/19 at 8:50 am			

Division of Health Service Regulation

STATE FORM 6899 0N4H11 If continuation sheet 26 of 73

DIVISION	n nealth Service Regu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			_			
					R	
		HAL053028	B. WING	<del></del>	08/1	6/2019
NAME OF D	ROVIDER OR SUPPLIER	QTDEET AD	DRESS, CITY, STA	TE ZID CODE		
NAME OF T	NOVIDEN ON 3011 LIEN					
ROYAL O	AKS ASSISTED LIVING		THAGE STREE	Т		
		SANFORE	), NC 27350			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DETIGIENOT)		
D 358	Continued From page	26	D 358			
	. •					
		ot receive the FL2 dated				
	02/26/19 for Resident					
	-The pharmacy received	ed the physician's orders				
	dated 02/14/19 for Re	esident #1.				
	-The physician's orde	r for Prezcobix was 800				
	mg-150 mg 1 tablet d	aily.				
	-On 07/28/19, a medi	cation aide (MA) at the				
	facility ordered Prezo	obix 800 mg-150 mg daily				
	through the eMAR.	g				
	-On 06/27/19, 30 table	ets of Prezcobix 800				
	mg-150 mg were disp					
	-On 07/29/19, 30 table					
	mg-150 mg were disp					
	mg roomg were dop	verioud.				
	Interview with MA on	08/15/19 at 12:22 pm				
	revealed:	σο, το, το ατ . <u></u> μ				
		cart" in the eMAR for				
	Prezcobix on 07/30/1					
		cart" meant they were either				
		art or ordered from the				
	pharmacy through the					
	, ,	der Prezcobix through the				
	•	•				
		ut was "rejected" because				
	Prezcobix was alread	y ordered by other staff.				
	Interview with Decide	nt #1 on 08/15/19 at 12:45				
		111 #1 011 06/15/19 at 12.45				
	pm revealed:	a of mandination at the and of				
		s of medication at the end of				
	July 2019.	te e e e e e e				
	•	his medications at the end				
		m the medications were at				
	-	vere for the August 2019				
		not be given in July 2019.				
		n and scared when he did				
		ous disease medications at				
	the end of July 2019.					
	-He did not feel the st	aff communicated with other				
	staff.					

Division of Health Service Regulation

Interview with Resident #1's primary care provider

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<u>Division c</u>	<u>of Health Service Regu</u>	ilation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL053028	B. WING		1	6/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STAT	TE. ZIP CODE		
			RTHAGE STREET			
ROYAL OA	AKS ASSISTED LIVING		D, NC 27350	•		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	(EACH DEFICIENC)	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIAIE	DATE
			+			
D 358	Continued From page	e 27	D 358			
	(PCP) on 08/15/19 at	t 3:30 pm revealed:				
		that Prezcobix was not				
		tal of 2 doses on 07/29/19				
	and 07/30/19.	that Drazashiv was not				
	administered as order	that Prezcobix was not ered because it was				
	prescribed for an infe					
	1 -	e Prezcobix for Resident #1.				
		cribed by an Infectious				
	Disease Provider.					
		nt for Resident #1 with the				
	PCP was on 06/11/19	<b>3</b> .				
	Interview with the Re	sident Care Coordinator				
	(RCC) on 08/15/19 at	t 4:46 pm revealed she did				
	not know why Reside					
	Prezcobix as ordered	d on 07/29/19 and 07/30/19.				
	Attempted telephone	interview with Resident #1's				
		rovider on 08/16/19 at 09:45				
	am was unsuccessful	l.				
	l <u></u>					
		th a representative from the				
	facility contracted pha	armacy 08/15/19 at 8:50 am.				
	Refer to interview wit	th the MA on 08/15/19 at				
	12:22 pm.					
	l <u></u>					
		th the Administrator on				
	08/15/19 at 4:20 pm a 	and 08/16/19 at 12:40 pm.				
	Refer to interview wit	th the RCC on 08/15/19 at				
	4:46 pm and 08/16/19					
	Refer to interview with					
	08/16/19 at 11:20 am	1.				
	c Review of Residen	nt #1's current FL2 dated				
		order for Abacavir 300 mg				

take 2 tablets daily. (Abacavir is an antiretroviral

STATE FORM 6899 If continuation sheet 28 of 73 0N4H11

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI	
7.1.12 . 27.1.1		.5	A. BUILDING: _			
HAL053028		B. WING		08/1	6/2019	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 55.1	<u></u>
TO WILL OF TH	TO VIDEN ON OUT FEEL		THAGE STREE			
ROYAL OAKS ASSISTED LIVING		, NC 27350	•			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	28	D 358			
	medication used to treat bloodborne infectious diseases).					
	Administration Record revealed:	1's electronic Medication d (eMAR) for July 2019				
		or Abacavir 300 mg 2 d to be administered at 8:00				
amAbacavir was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/29/19 at 8:00 am.						
	-Abacavir was not documented as administered due to "NOT ON CART" on 07/30/19 and 07/31/19 at 8:00 am.					
	-There were 3 doses tablets missed.	of Abacavir 300 mg 2				
	Review of Resident # revealed:	1's August 2019 eMAR				
		or Abacavir 300 mg 2 d to be administered at 8:00				
	amAbacavir was not documented as administered due to "NOT ON CART" on 08/01/19 at 8:00 amThere was 1 dose of Abacavir 300 mg 2 tablets					
	missed.					
	hand on 08/15/19 at 1 were 60 tablets of Aba (30-day supply) on 07	ent #1's medications on 10:30 am revealed there acavir 300 mg dispensed 7/01/19 with 28 tablets ining and available for				
	revealed:	sentative from the on 08/15/19 at 8:50 am ot receive the FL2 dated				

Division of Health Service Regulation

02/26/19 for Resident #1.

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Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL053028	B. WING		08/16/2019
		111/1200020			1 00/10/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
POVAL O	AKS ASSISTED LIVING	1107 CAR	THAGE STREE	Т	
KO IAL O	AND ADDID LIVING	SANFORI	D, NC 27350		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE
			+	,	
D 358	Continued From page	29	D 358		
	-The pharmacy receive	ed the physician's orders			
	dated 02/14/19 for Re	esident #1.			
	-On 07/28/19, a medi	cation aide (MA) at the			
	facility ordered Abaca	vir 300 mg 2 tablets daily			
	through the eMAR.				
	-On 06/27/19, 60 tabl	ets of Abacavir 300 mg were			
	dispensed.				
	-On 07/29/19, 60 tabl	ets of Abacavir 300 mg were			
	dispensed.				
		on 08/15/19 at 12:22 pm			
	revealed:				
		cart" in the eMAR for			
		ot on the cart on 07/30/19,			
	07/31/19, and 08/01/1				
		cart" meant they were either			
		art or ordered from the			
	pharmacy through the				
		der the Abacavir through the 7/31/19, and 08/01/19 but			
		se Abacavir was already			
	ordered by other staff	•			
	Interview with Reside	nt #1 on 08/15/19 at 12:45			
	pm revealed:				
		s of medication at the end of			
	July 2019 and beginn	•			
		his medications at the end			
		im the medications were at			
	_	vere for the August 2019			
		I not be given in July 2019.			
		n and scared when he did			
		ous disease medications at			
	the end of July 2019.	aff communicated with other			
		an communicated with other			
	staff.				
	Interview with Reside	nt #1's primary care provider			
	(PCP) on 08/15/19 at				

-She was not aware that Abacavir was not

STATE FORM 6899 0N4H11 If continuation sheet 30 of 73

DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					R	
		HAL053028	B. WING		08/1	6/2019
NAME OF D	DOMBED OD OUDDINED	OTDEET AS	DDEGG OITY OTA	TE 710 000E		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	II E, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING	1107 CAR	THAGE STREE	T		
NO IAL O	AITO AGGIOTED EIVIITO	SANFOR	D, NC 27350			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 250	0 " 15	00	D 250			
D 358	Continued From page	9 30	D 358			
	administered for a tot	al of 4 doses on 07/29/19,				
	07/30/19, 07/31/19, a					
		that Abacavir was not				
	administered as order					
	prescribed for an infe					
	•	e Abacavir for Resident #1.				
	-Abacavir was prescri	ibed by an Infectious				
	Disease Provider.					
	-The last appointmen	t for Resident #1 with the				
	PCP was on 06/11/19	).				
	Interview with the Res	sident Care Coordinator				
	(RCC) on 08/15/19 at	4:46 pm revealed she did				
	not know why Reside					
	Abacavir as ordered (					
	07/31/19, and 08/01/					
	07/31/19, and 06/01/	19.				
	T	interview with Resident #1's				
		ovider on 08/16/19 at 09:45				
	am was unsuccessful					
	Refer to interview with	h a representative from the				
	facility contracted pha	armacy 08/15/19 at 8:50 am.				
	Refer to interview with	h the MA on 08/15/19 at				
	12:22 pm.					
	r					
	Refer to interview with	h the Administrator on				
		and 08/16/19 at 12:40 pm.				
	00/13/19 at 4.20 pin a	and 00/10/19 at 12.40 pm.				
	Defer to intensious with	h the RCC on 08/15/19 at				
	4:46 pm and 08/16/19	at 12:30 pm.				
	D ( ( ) ( )	1.44				
	Refer to interview with					
	08/16/19 at 11:20 am					
	d. Review of Residen	t #1's current FL2 dated				
	02/26/19 revealed an	order for Metoprolol 50 mg				
		prolol is a beta blocker				
	medication used to tre					
	medication used to the	cat riyperterision).	1			

Division of Health Service Regulation

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Division of Health Service Regulation				<u> </u>		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL053028	B. WING		08/16/2019	
					1 *************************************	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
ROYAL O	AKS ASSISTED LIVING		RTHAGE STREE	Т		
		SANFOR	D, NC 27350	T.		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(7.0)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF		
				DEFICIENCY)		
D 250	Continued From page	- 24	D 358			
D 358	Continued From page	31	D 336			
		1's electronic Medication				
		d (eMAR) for July 2019:				
		for Metoprolol Succ ER				
		Extended Release) 50 mg				
		administered at 8:00 am.				
		was not documented as MED (medication) ON				
		RMACY" on 07/29/19 at 8:00				
	am.	(W// C)   01/07/20/10 at 0.00				
		was not documented as				
	administered due to "					
	07/30/19 at 8:00 am.					
	-There were 2 doses	of Metoprolol Succ ER 50				
	mg missed.					
		1's August 2019 eMAR				
	revealed:	. M				
		for Metoprolol Succ ER 50				
	am.	be administered at 8:00				
		was not documented as				
	administered due to "					
	08/01/19 at 8:00 am.					
	-There was 1 dose of	Metoprolol Succ ER 50 mg				
	missed.					
		ent #1's medications on				
		10:30 am revealed 30 tablets				
		R 50 mg dispensed on				
	for administration.	ets remaining and available				
	ioi auministration.					
	Interview with a repre	esentative from the facility				
		on 08/15/19 at 8:50 am				
	revealed:					
		ot receive the FL2 dated				
	02/26/19 for Resident					
	-The pharmacy receiv	ved the physician's orders				

Division of Health Service Regulation

dated 02/14/19 for Resident #1.

STATE FORM 6899 0N4H11 If continuation sheet 32 of 73

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
					R	
		HAL053028	B. WING		08/16/20	)19
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		THAGE STREE	т		
0(0.15	STIMMADA ST.		), NC 27350		N	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CO	(X5) DMPLETE DATE
D 358	Continued From page	e 32	D 358			
	facility ordered Metop through the eMAR.  -On 06/27/19, 30 tabl 50 mg were dispenseOn 07/29/19, 30 tabl 50 mg were dispense. Interview with the MA revealed: -She selected "not on Metoprolol that was not and 08/01/19Medications "not on not available on the copharmacy through the She attempted to order.	ets of Metoprolol Succ ER id.  on 08/15/19 at 12:22 pm  cart" in the eMAR for not on the cart on 07/30/19  cart" meant they were either art or ordered from the e eMAR. der the Metoprolol through 9 and 08/01/19 but was etoprolol was already				
	pm revealed: -He did not get 3 days July 2019 and beginn -When he did not get of July, the MA told hi the facility, but they w cycle, and they would -He did not feel the st staff.  Interview with Reside (PCP) on 08/15/19 at -She was not aware t administered for a tot 07/30/19, and 08/01/2 -Metoprolol was prese	his medications at the end im the medications were at vere for the August 2019. I not be given in July 2019. I aff communicated with other on the H1's primary care provider 3:30 pm revealed: hat Metoprolol was not al of 3 doses on 07/29/19,				

Division of Health Service Regulation

administered as ordered.

STATE FORM 6899 0N4H11 If continuation sheet 33 of 73

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY. STATE, ZIP CODE 1107 CARTHAGE STREET SUMMARY STATEMENT OF DEPICIENCIES (PACH DEPICIENCY MUST AE PRECEDED OF YOLL). PRETEN  (PACH DEPICE OR OR SUPPLIER)  10 PROVIDER'S PLAN OF COMPRETING  PRETEN  (PACH DEPICE OR OR SUPPLIER)  10 PROVIDER'S PLAN OF COMPRETING  (PACH DEPICE OR OR SUPPLIER)  (PACH DEPICE OR	Division of	of Health Service Regu	liation				
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, 2IP CODE  1107 CARTHAGE STREET SAMFORD, NO. 27380  SUMMARY STATEMENT OF DEPTICENDIES  SAMFORD, NO. 27380  SUMMARY STATEMENT OF DEPTICENDIES  ANFORD, NO. 27380  SUMMARY STATEMENT OF DEPTICENDIES  CRAFT DEPTICENCY MUST BE PRECEDED BY PULL PREFIX TAG.  D 358  Continued From page 33  -When Resident #1 was not administered Metoprofol as ordered, he was at an increased risk for typetrensionThe last appointment for Resident #1 with the PCP was no 061119The BP was not collected at the facility for July 2019Staff documented BP of 165/118 on 08/15/19 at 2:15 pm.  Interview with the Resident #1 do not receive Metoprofol as ordered no 107/29/19, 07/30/19 and not know why Resident #1 did not receive Metoprofol as ordered on 07/29/19, 07/30/19 and no 08/01/19.  Refer to interview with the Administrator on 08/15/19 at 4:20 pm and 08/16/19 at 12:30 pm.  Refer to interview with the RCC on 08/15/19 at 4:46 pm and 08/16/19 at 12:30 pm.  Refer to interview with the RCC on 08/15/19 at 4:46 pm and 08/16/19 at 12:30 pm.  Refer to interview with the second MA on 08/15/19 at 4:20 pm and 08/16/19 at 12:30 pm.  Refer to interview with the second MA on 08/15/19 at 4:20 pm and 08/16/19 at 12:30 pm.  Refer to interview with the second MA on 08/15/19 at 1:20 am.  e. Review of Resident #1's current FL2 dated 02/28/19 revealed an order for Lisinoprii 20 mg 1 tablet daily. (Lisinoprii is an angiotension converting enzyme (ACE) inhibitor used to freat hypertension).				(X2) MULTIPLE	CONSTRUCTION		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, JIP CODE: 1107 CARTHAGE STREET SAMFORD, NC 27359  SUMMARY STATEMENT OF DEFICIENCES  SUMMARY STATEMENT OF DEFICIENCES  SUMMARY STATEMENT OF DEFICIENCES  SAMFORD, NC 27359  SUMMARY STATEMENT OF DEFICIENCES  SAMFORD, NC 27359  SUMMARY STATEMENT OF DEFICIENCES  SAMFORD, NC 27359  SAMFORD, NC 27359  SUMMARY STATEMENT OF DEFICIENCES  SAMFORD, NC 27359  SUMMARY STATEMENT OF DEFICIENCES  SAMFORD, NC 27359  SUMMARY STATEMENT OF DEFICIENCES  D PROVIDERS PLAN OF CORRECTION PROJULD BY PACE (PACH CORRECTIVE A) TO NO PACE (PACH CORRECTIVE A)	AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
NAME OF PROVIDER OR SUPPLIER  ROYAL OAKS ASSISTED LIVING  SUMMANY RIVINDAMY OF SECRETARIAGE STREET SANFORD, NC 27380  PROVIDER OR SUPPLIER  SUMMANY RIVINDAMY OF SECRETARIAGE STREET SANFORD, NC 27380  PROVIDER OR SUMMANY RIVINDAMY OF SECRETARIAGE SANFORD, NC 27380  PROVIDER OR SANFORD, NC 27380  PROVIDERS RAM OF CORRECTION (SALD BE PROPERTIED BY TYLL), RECULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 33  -When Resident #1 was not administered Metoprolol as ordered, he was at an increased risk for hypertensionThe last appointment for Resident #1 with the PCP was no 06/11/19The BP was not collected at the facility for July 2019Staff documented BP of 165/118 on 08/15/19 at 2.15 pm.  Interview with the Resident Care Coordinator (RCC) on 08/15/19 at 1.46 pm revealed she did not know why Resident #1 did not receive Metoprolol as ordered on 07/29/19, 07/30/19 and on 08/01/19.  Refer to interview with a representative from the facility contracted pharmacy 08/15/19 at 1.20 pm.  Refer to interview with the Administrator on 08/15/19 at 1.23 pm.  Refer to interview with the RCC on 08/15/19 at 1.23 pm.  Refer to interview with the Second MA on 08/16/19 at 1.23 pm.  Refer to interview with the second MA on 08/16/19 at 1.20 pm and 08/16/19 at				·		_	
NAME OF PROVIDER OR SUPPLIER  ROYAL OAKS ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES SAMPORD, NC 27380  PREFIX TAG  CROUNDERFORM STATEMENT OF DEFICIENCIES SAMPORD, NC 27380  PREFIX TAG  CROUNDERFORM STATEMENT OF DEFICIENCIES SAMPORD, NC 27380  CONTINUED FROM STATEMENT OF DEFICIENCIES SAMPORD, NC 27380  CONTINUED FROM STATEMENT OF DEFICIENCIES SAMPORD, NC 27380  CROSS REFERENCED TO THE APPROPRIATE ONE CHARLES SAMPORD, NC 27380  CROSS REFERENCED TO THE APPROPRIATE ONE CHARLES SAMPORD, NC 27380  CROSS REFERENCED TO THE APPROPRIATE ONE CHARLES SAMPORD, NC 27380  CROSS REFERENCED TO THE APPROPRIATE ONE CHARLES SAMPORD, NC 27380  CROSS REFERENCED TO THE APPROPRIATE ONE CHARLES SAMPORD, NC 27380  CROSS REFERENCED TO THE APPROPRIATE ONE CROSS REFERENCED TO THE CROSS TO THE CROSS TO THE CROSS TO T				D WING			
CALL CORRECTION   CASHED LIVING   SUMMARY STATEMENT OF DEFICIENCIES   SANFORD, NC 27380   PREFIX   TAG   DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   TAG   DEPRETIX   TAG   CASHED CONTROLL OF CO			HAL053028	B. WING		08/1	6/2019
CALL CORRECTION   CASHED LIVING   SUMMARY STATEMENT OF DEFICIENCIES   SANFORD, NC 27380   PREFIX   TAG   DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   TAG   DEPRETIX   TAG   CASHED CONTROLL OF CO	NAME OF D	DU/IDED UD SLIDDI IED	STDEET AD	INDESS CITY STA	TE ZID CODE		
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08/15/19 at 4:20 pm and 08/16/19 at 12:40 pm.  Refer to interview with the RCC on 08/15/19 at 4:46 pm and 08/16/19 at 12:30 pm.  Refer to interview with the second MA on 08/16/19 at 11:20 am.  e. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Lisinopril 20 mg 1 tablet daily. (Lisinopril is an angiotension converting enzyme (ACE) inhibitor used to treat hypertension).		Pofor to intonvious with	h the Administrator on				
Refer to interview with the RCC on 08/15/19 at 4:46 pm and 08/16/19 at 12:30 pm.  Refer to interview with the second MA on 08/16/19 at 11:20 am.  e. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Lisinopril 20 mg 1 tablet daily. (Lisinopril is an angiotension converting enzyme (ACE) inhibitor used to treat hypertension).							
4:46 pm and 08/16/19 at 12:30 pm.  Refer to interview with the second MA on 08/16/19 at 11:20 am.  e. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Lisinopril 20 mg 1 tablet daily. (Lisinopril is an angiotension converting enzyme (ACE) inhibitor used to treat hypertension).		00/15/19 at 4.20 pm a	and 00/10/19 at 12.40 pm.				
4:46 pm and 08/16/19 at 12:30 pm.  Refer to interview with the second MA on 08/16/19 at 11:20 am.  e. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Lisinopril 20 mg 1 tablet daily. (Lisinopril is an angiotension converting enzyme (ACE) inhibitor used to treat hypertension).		Defende intensionalist	h the DCC on 00/45/40 of				
Refer to interview with the second MA on 08/16/19 at 11:20 am.  e. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Lisinopril 20 mg 1 tablet daily. (Lisinopril is an angiotension converting enzyme (ACE) inhibitor used to treat hypertension).							
e. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Lisinopril 20 mg 1 tablet daily. (Lisinopril is an angiotension converting enzyme (ACE) inhibitor used to treat hypertension).		4:46 pm and 08/16/18	9 at 12:30 pm.				
e. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Lisinopril 20 mg 1 tablet daily. (Lisinopril is an angiotension converting enzyme (ACE) inhibitor used to treat hypertension).		5					
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02/26/19 revealed an order for Lisinopril 20 mg 1 tablet daily. (Lisinopril is an angiotension converting enzyme (ACE) inhibitor used to treat hypertension).		08/16/19 at 11:20 am					
02/26/19 revealed an order for Lisinopril 20 mg 1 tablet daily. (Lisinopril is an angiotension converting enzyme (ACE) inhibitor used to treat hypertension).							
tablet daily. (Lisinopril is an angiotension converting enzyme (ACE) inhibitor used to treat hypertension).							
converting enzyme (ACE) inhibitor used to treat hypertension).							
hypertension).			•				
		converting enzyme (A	ACE) inhibitor used to treat				
Deview of Decident #41s electronic Medication		, ,					
Review of Resident #1's electronic Medication		Review of Resident #	1's electronic Medication				
Administration Record (eMAR) for July 2019:							
-There was an entry for Lisinopril 20 mg daily							

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  ROYAL OAKS ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES TAG  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 34 scheduled to be administered at 8:00 amLisinopril was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/29/19 at 8:00 amLisinopril was not documented as administered due to "NOT ON CART" on 07/30/19 at 8:00 amThere were 2 doses of Lisinopril 20 mg missed.  Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed 30 tablets of Lisinopril 20 mg were dispensed on 07/01/19 with 14 tablets remaining and available for administration.  Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed: -The pharmacy did not receive the FL2 dated	EMENT OF DEFICIENCIES PLAN OF CORRECTION
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1107 CARTHAGE STREET SANFORD, NC 27350  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG STREET SANFORD, NC 27350  D 358  Continued From page 34  Scheduled to be administered at 8:00 amLisinopril was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/29/19 at 8:00 amLisinopril was not documented as administered due to "NOT ON CART" on 07/30/19 at 8:00 amThere were 2 doses of Lisinopril 20 mg missed.  Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed 30 tablets of Lisinopril 20 mg were dispensed on 07/01/19 with 14 tablets remaining and available for administration.  Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed: -The pharmacy did not receive the FL2 dated	LAN OF CONNECTION
ROYAL OAKS ASSISTED LIVING    CAMPUT   CARTHAGE STREET   SANFORD, NC 27350	
ROYAL OAKS ASSISTED LIVING  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 34  scheduled to be administered at 8:00 amLisinopril was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/29/19 at 8:00 amLisinopril was not documented as administered due to "NOT ON CART" on 07/30/19 at 8:00 amThere were 2 doses of Lisinopril 20 mg missed.  Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed 30 tablets of Lisinopril 20 mg were dispensed on 07/01/19 with 14 tablets remaining and available for administration.  Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed: -The pharmacy did not receive the FL2 dated	E OF PROVIDER OR SUPPLIE
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358 Continued From page 34 Scheduled to be administered at 8:00 amLisinopril was not documented as administered due to "NOT ON CART" on 07/30/19 at 8:00 amThere were 2 doses of Lisinopril 20 mg missed.  Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed 30 tablets of Lisinopril 20 mg were dispensed on 07/01/19 with 14 tablets remaining and available for administration.  Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed: -The pharmacy did not receive the FL2 dated	AL OAKS ASSISTED LI
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 34  scheduled to be administered at 8:00 amLisinopril was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/29/19 at 8:00 amLisinopril was not documented as administered due to "NOT ON CART" on 07/30/19 at 8:00 amThere were 2 doses of Lisinopril 20 mg missed.  Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed 30 tablets of Lisinopril 20 mg were dispensed on 07/01/19 with 14 tablets remaining and available for administration.  Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed: -The pharmacy did not receive the FL2 dated	AL OARS ASSISTED EI
scheduled to be administered at 8:00 am.  -Lisinopril was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/29/19 at 8:00 am.  -Lisinopril was not documented as administered due to "NOT ON CART" on 07/30/19 at 8:00 am.  -There were 2 doses of Lisinopril 20 mg missed.  Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed 30 tablets of Lisinopril 20 mg were dispensed on 07/01/19 with 14 tablets remaining and available for administration.  Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed:  -The pharmacy did not receive the FL2 dated	EFIX (EACH DEF
-Lisinopril was not documented as administered due to "MED (medication) ON ORDER FROM PHARMACY" on 07/29/19 at 8:00 amLisinopril was not documented as administered due to "NOT ON CART" on 07/30/19 at 8:00 amThere were 2 doses of Lisinopril 20 mg missed.  Observation of Resident #1's medications on hand on 08/15/19 at 10:30 am revealed 30 tablets of Lisinopril 20 mg were dispensed on 07/01/19 with 14 tablets remaining and available for administration.  Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed: -The pharmacy did not receive the FL2 dated	358 Continued Fron
02/26/19 for Resident #1.  -The pharmacy received the physician's orders dated 02/14/19 for Resident #1.  -On 07/28/19, a medication aide (MA) at the facility ordered Lisinopril 20 mg daily through the eMAR.  -On 06/27/19, 30 tablets of Lisinopril 20 mg were dispensed.  -On 07/29/19, 30 tablets of Lisinopril 20 mg were dispensed.  Interview with the MA on 08/15/19 at 12:22 pm revealed:  -She selected "not on cart" in the eMAR for Lisinopril that was not on the cart on 07/30/19.  -Medications "not on cart" meant they were either not available on the cart or ordered from the pharmacy through the eMAR.  -She attempted to order Lisinopril through the	scheduled to be -Lisinopril was reduce to "MED (metal Pharmacy of the contracted pharmacy of the pharmacy of t

Division of Health Service Regulation

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL053028	B. WING		R 08/16/2019	
	ROVIDER OR SUPPLIER  AKS ASSISTED LIVING	STREET AD	DRESS, CITY, STA THAGE STREE D, NC 27350		, 00.10.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 358	pm revealed: -He did not get 2 days July 2019When he did not get of July, the MA told hi the facility, but they w cycle, and they would -He did not feel the st staff.  Interview with Reside (PCP) on 08/15/19 at -She was not aware t administered for a tot and 07/30/19Lisinopril was prescr -She was concerned administered as ordered, for hypertensionThe last appointmen PCP was on 06/11/19 -The BP was not colle 2019Staff documented BF 2:15 pm.  Interview with the Res (RCC) on 08/15/19 at not know why Reside Lisinopril as ordered of Refer to interview with facility contracted phase	ant #1 on 08/15/19 at 12:45 so of medication at the end of this medications at the end m the medications were at the ere for the August 2019 and be given in July 2019. aff communicated with other of the August 2019 are provider 3:30 pm revealed: that Lisinopril was not all of 2 doses on 07/29/19 at the Lisinopril was not red. The area at an increased risk at for Resident #1 with the content at the facility for July are of 165/118 on 08/15/19 at the sident Care Coordinator 4:46 pm revealed she did	D 358			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		(X3) DATE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:	
					R
		HAL053028	B. WING		08/16/2019
NAME OF D			DECC CITY CTA	TE 7/D 00DE	1 00:10:20:0
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	•	
ROYAL O	AKS ASSISTED LIVING		HAGE STREE	ı	
			NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 36	D 358		
	Refer to interview with the Administrator on 08/15/19 at 4:20 pm and 08/16/19 at 12:40 pm.				
	Refer to interview with 4:46 pm and 08/16/19	n the RCC on 08/15/19 at 9 at 12:30 pm.			
	Refer to interview with 08/16/19 at 11:20 am				
	f. Review of Resident #1's current FL2 dated 02/26/19 revealed an order for Incruse Ellipta 1 time daily. (Incruse Ellipta is an anticholinergic medication used to treat COPD).				
	Administration Recordant - There was an entry finhaler 1 puff daily so at 8:00 am.  -There was an entry the self-administered and ellipta was not administered due to CRDER FROM PHARMINISTER Ellipta was not administered due to 707/30/19 and 07/31/1	ot documented as MED (medication) ON RMACY" on 07/29/19. ot documented as NOT ON CART" on			
	revealed: -There was an entry f inhaler 1 puff daily so at 8:00 amThere was an entry t self-administered and -Incruse Ellipta 62.5 r	1's August 2019 eMAR or Incruse Ellipta 62.5 mcg heduled to be administered hat Incruse Ellipta may be I kept in the room. ncg inhaler 1 puff was not histered due to "NOT ON			

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CART" on 08/01/19.

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE (X3) DATE SURVE (X4) PLAN OF CORRECTION (DENTIFICATION NUMBER: A PLAN DESCRIPTION (COMPLETED					
74401 2744	or connection	IDENTIFICATION NO.	A. BUILDING:			
			D. WING			R
		HAL053028	B. WING		08	/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
DO)/41 O	ALCO A COLOTED I INVINC	1107 CA	RTHAGE STREET			
ROYAL O	AKS ASSISTED LIVING	SANFOR	RD, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 37	D 358			
	-There was 1 dose of missed.	Incruse Ellipta 62.5 mcg				
	Observation of Resident #1's room for medications on hand on 08/15/19 at 10:30 am revealed Incruse Ellipta was not available for administration.  Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed:  -The pharmacy did not receive the FL2 dated 02/26/19 for Resident #1.  -The pharmacy received the physician's orders					
	dated 02/14/19 for Re- -The physician's orde					
	-On 07/28/19, a medi facility ordered Incrus through the eMAR.	cation aide (MA) at the e Ellipta 62.5 mcg daily				
	-On 07/30/19, a 30-da	ay supply was dispensed. ay supply was dispensed. of August 2019, the July vas returned to the				
	returned.	y the Incruse Ellipta was				
	Interview with Reside	nt #1's primary care provider				
	administered as order 07/31/19, and 08/01/	hat Incruse Ellipta was not red on 07/29/19, 07/30/19, 19.				
	treat COPD.	rdered by a pulmonologist to				
	administered as order	that Incruse Ellipta was not red.  vas not administered Incruse				
		was at an increased risk for				

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STATE FORM 6899 0N4H11 If continuation sheet 38 of 73

Division of	of Health Service Regu	lation			
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		R
		HAL053028	B. WING		08/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STAT	E, ZIP CODE	
ROYAL O/	AKS ASSISTED LIVING		THAGE STREET	•	
1101112		SANFORI	D, NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 38	D 358		
		n and shortness of breath. t for Resident #1 with the 9.			
	am revealed: -He had episodes of swheezingHe stored the Incruse-He had not had Incruse-The facility was respmedicationsHe informed the staff	shortness of breath and e Ellipta in his room. use Ellipta in 3-4 weeks. onsible for ordering the			
	Ellipta several times ( never received the mo- -The staff did not che medication.	ck to see if he had taken his			
	-The staff did not che order medication.	ck to see if he needed to			
	revealed: -She did not check th Resident #1's roomShe selected "not on Incruse Ellipta that wa 07/30/19, 07/31/19, a -Medications "not on				
	or ordered from the p -She attempted to ord the eMAR that was no 07/31/19, and 08/01/	harmacy through the eMAR. der Incruse Ellipta through ot on the cart 07/30/19,			

pm revealed:

Interview with Resident #1 on 08/15/19 at 12:45

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
						,
			B. WING		R	
		HAL053028	D. WING	<del></del>	08/1	6/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1107 CAR	THAGE STREE	Т		
ROYAL O	AKS ASSISTED LIVING		), NC 27350	•		
			7, 140 27330	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
1710		,	17.0	DEFICIENCY)		
D 358	Continued From page	e 39	D 358			
	-He did not get 4 days	s of medication at the end of				
	July 2019 and beginn					
	-	his medications at the end				
		im the medications were at				
	•	vere for the August 2019				
	-	I not be given in July 2019.				
	-	aff communicated with other				
	staff.	an communicated with other				
	Stall.					
	Interview with the Adr	ministrator on 08/15/19 at				
		Till istrator on 00/15/19 at				
	4:20 pm revealed:	hat Inarusa Ellinta was in				
		hat Incruse Ellipta was in				
	Resident #1's room.	-t D:-				
		at Resident #1 was out of the				
	Incruse Ellipta.					
		ted in the eMAR, a note				
	should state self-adm					
	-	aff to ask Resident #1 if he				
	self-administered Incr	ruse Ellipta.				
		sident Care Coordinator				
	(RCC) on 08/15/19 at	•				
	-She was aware that	Incruse Ellipta was in				
	Resident #1's room.					
		at Resident #1 was out of				
	Incruse Ellipta.	,, , , , , , , , , , , , , , , , , , , ,				
		was self-administered, the				
		on the eMAR by writing				
	•	ould be done with each				
	administration.					
		y Resident #1 did not				
	•	a as ordered from 07/29/19,				
	07/30/19, 07/31/19, a	nd 08/01/19.				
		nd MA on 08/16/19 at 11:20				
	am revealed:					
	-She was aware of the	e Incruse Ellipta in Resident				
	#1's room.					
	-She did not know that	at Resident #1 was out of the				

Division of Health Service Regulation

Incruse Ellipta.

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DIVISION	i Health Service Regu	alion				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLE	
ANDIEAN	O CONTROLLON	IDENTIFICATION NOMBER.	A. BUILDING: _	<del></del>	OOWII EL	LILD
			D WING		R	
		HAL053028	B. WING		08/1	6/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING	1107 CART	HAGE STREE	т		
KOTAL O	AND ADDIDIED LIVING	SANFORD,	NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	<del>2</del> 40	D 358			
	-Resident #1 would no getting low on his inhall-she would ask Resideself-administered med-she had not noticed or wheezing.  Refer to interview with facility contracted phase resident with the self-she had not noticed or wheezing.  Refer to interview with the self-she had not noticed or wheezing.  Refer to interview with the self-she had not noticed or wheezing.  Refer to interview with the self-she had at the self-she had at the self-she had not not self-she had not not self-she had not self-she had not self-she had not self-she had not self-she had not self-she had not not self-she had not not self-she had not self-she had not self-she had not not self-she had not s	otify the MA when he was alers.  Itent #1 if he was low on dications every other shift. Resident #1 short of breath a representative from the armacy 08/15/19 at 8:50 am.  In the MA on 08/15/19 at  In the Administrator on and 08/16/19 at 12:40 pm.  In the RCC on 08/15/19 at  In the second MA on  It #1's current FL2 dated order for Duloxetine 20 mg loxetine is a medication ion, anxiety, and pain).  It's electronic Medication of (eMAR) for July 2019: or Duloxetine 20 mg 2 uled to be administered at locumented as administered tion) ON ORDER FROM 19/19 at 8:00 am. capsules was not				
	documented as admir CART" on 07/30/19 at	nistered due to "NOT ON				

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capsules missed.

STATE FORM 6899 0N4H11 If continuation sheet 41 of 73

DIVISION	of Health Service Regu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
				<del></del>	l _	, l
			B. WING		F	
		HAL053028	B. WING		08/1	6/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		THAGE STREE	1		
		SANFORI	), NC 27350			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	NEGOLATON ON	ESCIDENTIF FING IN CHIMATION)	TAG	DEFICIENCY)	MAIL	57.1.2
				,		
D 358	Continued From page	e 41	D 358			
	. •					
		ent #1's medications on				
		10:30 am revealed 60				
		oply) of Duloxetine 20 mg				
	•	7/01/19 with 28 capsules				
	(14-day supply) rema	ining and available for				
	administration.					
	Interview with a repre	esentative from the				
	contracted pharmacy	on 08/15/19 at 8:50 am				
	revealed:					
	-The pharmacy did no	ot receive the FL2 dated				
	02/26/19 for Resident					
	-The pharmacy receiv	ved the physician's orders				
	dated 02/14/19 for Re					
	-On 07/28/19, a medi	ication aide (MA) at the				
		etine 20 mg 2 capsules daily				
	through the eMAR.	3, · · · · · · · · · · · · · · · · ·				
		sules of Duloxetine 20 mg				
	were dispensed.	calce of Balexonne 20 mg				
	•	sules of Duloxetine 20 mg				
	were dispensed.	balos of Baloxotine 20 mg				
	word dioportiona.					
	Interview with the MA	on 08/15/19 at 12:22 pm				
	revealed:	10.1 30/10/10 at 12.22 pm				
		cart" in the eMAR for				
		not on the cart on 07/30/19.				
		cart" meant they were either				
		cart or ordered from the				
	pharmacy through the					
		der Duloxetine through the				
		ut was "rejected" because				
	Duloxetine was alread	dy ordered by other staff.				
		ent #1 on 08/15/19 at 12:45				
	pm revealed:					
	-He did not get 2 days	s of medication at the end of				
	July 2019.					
	-When he did not get	his medications at the end				
		im the medications were at				

Division of Health Service Regulation

STATE FORM 6899 0N4H11 If continuation sheet 42 of 73

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL053028	B. WING		R 08/16/2019
	ROVIDER OR SUPPLIER  AKS ASSISTED LIVING	1107 CAR	DRESS, CITY, STA THAGE STREE D, NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	the facility, but they we cycle, and they would -He felt increased pai he did not receive his July 2019.  -He did not feel the st staff.  Interview with the Res (RCC) on 08/15/19 at not know why Reside Duloxetine as ordered Interview with the Nur Resident #1's mental at 10:43 am revealed -Duloxetine was ordered -She did not know Resident #1 was ordered -She was not notified receive his Duloxetine and 07/30/19.  -When Resident #1 was verif he had not received increased anxietyResident #1 was verif he had not received -She expected medic and on timeResident #1 was last week of August 2019.  Interview with Reside am revealed: -He noticed increased difficulty sleeping when Duloxetine at the end -When Duloxetine was and the side am revealed: -He noticed increased difficulty sleeping when Duloxetine at the end -When Duloxetine was received and on time and the end -When Duloxetine was received -She expected increased difficulty sleeping when Duloxetine at the end -When Duloxetine was received -She expected increased difficulty sleeping when Duloxetine at the end -When Duloxetine was received -She expected increased difficulty sleeping when Duloxetine at the end -When Duloxetine was received -She expected increased difficulty sleeping when Duloxetine at the end -When Duloxetine was received -She expected increased difficulty sleeping when Duloxetine was received -She expected increased difficulty sleeping when Duloxetine was received -She expected increased difficulty sleeping when Duloxetine was received -She expected increased difficulty sleeping when Duloxetine was received -She expected increased difficulty sleeping when Duloxetine was received -She expected increased difficulty sleeping when Duloxetine was received -She expected increased -She expected increased -She expected -She expecte	rere for the August 2019 I not be given in July 2019. In and mood swings when Duloxetine at the end of aff communicated with other  sident Care Coordinator 4:4:46 pm revealed she did Int #1 did not receive Id on 07/29/19 and 07/30/19.  The Practitioner (NP) from I health provider on 08/16/19 I red for anxiety and hip pain. I sident #1 did not receive his I do n 07/29/19 and 07/30/19. I that Resident #1 did not I e as ordered on 07/29/19  That Resident #1 did not I e as ordered on 07/29/19  That Resident #1 did not I e as ordered on 07/29/19  That was at risk for I y competent and would ask I his medication. I ations to be given accurately I seen by the NP the first I seen by the NP the first I danxiety, mood swings, and I anxiety, mood swings, and I he did not receive	D 358		

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sleeping decreased.

STATE FORM 6899 0N4H11 If continuation sheet 43 of 73

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:	
					R
		HAL053028	B. WING		08/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-
		1107 CART	HAGE STREE	т	
ROYAL O	AKS ASSISTED LIVING		, NC 27350		
	OLIMANA DV OT		<u> </u>	PROVIDERIO PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 43	D 358		
	revealed she did not s #1's sleep pattern or in August 2019.  Refer to interview with facility contracted phane Refer to interview with 12:22 pm.  Refer to interview with 08/15/19 at 4:20 pm and Refer to interview with 4:46 pm and 08/16/19 Refer to interview with 08/16/19 at 11:20 am  h. Review of Residen 03/07/19 revealed an mg 1 tablet daily (Hyoused to treat itching, and Review of Resident # Administration Record -There was an entry f tablets daily schedule pmHydroxyzine was not administered due to " ORDER FROM PHAR 07/29/19, and 07/30/1	t #1's current FL2 dated order for Hydroxyzine 10 droxyzine is a medication anxiety and aide in sleep)  t1's electronic Medication d (eMAR) for July 2019: for Hydroxyzine 10 mg 2 and to be administered at 6:00 at documented as MED (medication) ON RMACY" on 07/28/19,			
	ORDER FROM PHAR 07/29/19, and 07/30/1 -There were 3 doses tablets missed.	RMACY" on 07/28/19, 19 at 6:00 pm.			

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hand on 08/15/19 at 10:30 am revealed 60 tablets

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		HAL053028	B. WING		R	₹ 1 <b>6/2019</b>
NAME OF D			DDECC CITY CTA	TE 7/D 000E	1 00/1	0/2013
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	•		
ROYAL O	AKS ASSISTED LIVING		THAGE STREE D, NC 27350	ı		
(Y4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	<u> </u>	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
D 358	Continued From page	2 44	D 358			
		droxyzine 10 mg were 9 with 32 tablets (16-day d available for				
	Interview with a representative from the contracted pharmacy on 08/15/19 at 8:50 am revealed:					
	-The pharmacy did no 02/26/19 for Resident					
	dated 02/14/19 for Re	ved the physician's orders esident #1. t order was sent from the				
	Nurse Practitioner (N 10 mg to 2 tablets at	P) to increase Hydroxyzine				
	through the eMAR.	xyzine 10mg 2 tablets daily ets of Hydroxyzine 10 mg				
	were dispensedOn 07/31/19, 60 tabl were dispensed.	ets of Hydroxyzine 10 mg				
	pm revealed:	nt #1 on 08/15/19 at 12:45				
	July 2019.	s of medication at the end of				
	of July, the MA told h	his medications at the end im the medications were at vere for the August 2019				
	-He felt mood swings Hydroxyzine at the er	-				
	-He did not feel the st staff.	aff communicated with other				
		sident Care Coordinator 4:46 pm revealed she did nt #1 did not receive				

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Hydroxyzine as ordered from 07/28/19, 07/29/19,

STATE FORM 6899 0N4H11 If continuation sheet 45 of 73

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPL	
		HAL053028	B. WING		F 08/1	6/2019
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	TE, ZIP CODE	1 00/1	0,2010
ROYAL OA	AKS ASSISTED LIVING		THAGE STREET D, NC 27350	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Resident #1's mental at 10:43 am revealed -Hydroxyzine was ord sleepShe did not know Re Hydroxyzine as order and 07/30/19She was not notified receive his Hydoxyzin 07/29/19, and 07/30/1-When Resident #1 w Hydroxyzine as order increased anxietyResident #1 was verif he had not received -She expected medical and on timeResident #1 was last August 2019.  Interview with Reside am revealed: -He noticed increased difficulty sleeping whe Hydroxyzine at the en-He slept less hours whydroxyzine at the en-When Hydroxyzine win August 2019, the as sleeping decreased.  Interview with the RC revealed she did not resident with the RC revealed she did not resident revealed.	rse Practitioner (NP) from health provider on 08/16/19 : lered for itching, anxiety, and esident #1 did not receive ed on 07/28/19, 07/29/19, that Resident #1 did not he as ordered on 07/28/19, 19. ras not administered ed, he was at risk for ly competent and would ask l his medication. ations to be given accurately the seen the first week of anxiety, mood swings, and en he did not receive his his d of July 2019. when he did not receive hid of July 2019. when he did not receive hid of July 2019. was administered as ordered anxiety and issues with  C on 08/16/19 at 12:30 pm notice any changes in	D 358			
		attern or mood the in July				

Refer to interview with a representative from the

STATE FORM 6899 0N4H11 If continuation sheet 46 of 73

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL053028	B. WING		08	R 8/ <b>16/2019</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ROYAL C	AKS ASSISTED LIVING		RTHAGE STREET RD, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	facility contracted phase Refer to interview with 12:22 pm.  Refer to interview with 12:22 pm.  Refer to interview with 4:20 pm and 08/15/19 at 4:20 pm and 08/16/19  Refer to interview with 4:46 pm and 08/16/19  Refer to interview with at 11:20 am. 2. Review of Resident 08/06/19 revealed: -Diagnoses included disorder, anemia, hypothyroid functionThere was an order streat moderate to several aday.  Review of Resident # revealed an order for times a day, on 05/14  Review of Resident # Medication Administrative aled: -There was an entry for scheduled to be administrative administrative and 150 pm a	h the MA on 08/15/19 at  the the Administrator on and 08/16/19 at 12:40 pm.  the the RCC on 08/15/19 at 20 at 12:30 pm.  the a second MA on 08/16/19  at #2's current FL-2 dated  left wrist fracture, bi-polar pertension and abnormal  for Tramadol HCL (used to pere pain) 50 mg three times  E2's physician's orders  Tramadol 50 mg three  E2's June 2019 electronic ation Record (eMAR)  for Tramadol 50 mg and inistered three times a day and 8:00 pm.  Is not documented as 9/19 at 8:00 pm, on on 06/12/19 at 8:00 pm, on on 06/12/19 at 8:00 pm, on on 06/14/19 at 8:00 am, on	D 358			

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STATE FORM 6899 0N4H11 If continuation sheet 47 of 73

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) AND PLAN OF CORRECTION (X5) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTR		l \ /	E SURVEY PLETED			
						R
		HAL053028	B. WING		08	3/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING	1107 CAR	THAGE STREET	Ī		
		SANFORI	D, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 47	D 358			
	was not administered to Resident #2There were 8 doses of Tramadol 50 mg not documented as administered for pain on the June 2019 eMAR.					
	scheduled to be admi at 8:00 am, 2:00 pm a -Tramadol 50 mg was administered on 07/0 07/22/19 at 8:00 am a on 07/26/19 at 8:00 a at 8:00 pm, on 07/28/ 07/29/19 at 8:00 am. -"Out of Facility with fi the reason the Trama Resident #2. -There was no docum mg was given to Resi the facility. -There were 8 doses	for Tramadol 50 mg and inistered three times a day and 8:00 pm. In and 2:00 pm, on and 2:00 pm, on and 2:00 pm, on 07/27/19 at 8:00 am and on and 2:00 pm and 0:00 pm, on 07/27/19 at 8:00 am and on and of the angle of				
	was when the medical were waiting on the pull of a medication was guardlets left, the MA was delivered from the phus of the medications a	revealed: dent #2 was not madol 50 mg in June 2019, ation ran out and the MAs harmacy to send it. getting low, maybe 2-3 build place an order to be armacy. rrived in crates from the d check in the medications e medication cart; the				

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medication cart and administered until checked

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	ED
			1	_	_	
			D WING		R	
		HAL053028	B. WING		08/16/2	2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		THAGE STREE	1		
		SANFORD	, NC 27350			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE	DAIL
				,		
D 358	Continued From page	e 48	D 358			
	in.					
	-The pharmacy crates	s were stored in the back				
	office.					
	-If a medication pass	was in process and the				
	Tramadol was not in t	the medication cart, a "med				
	on order from the pha	armacy" note would be made				
	in the computer and t	he medication pass would				
	continue.					
	Interview on 08/16/19	at 12:21 pm with a second				
	MA revealed:	•				
	-The times in July 201	19 when Resident #2 was				
		madol 50 mg was when the				
		der from the pharmacy or				
	the resident was out of					
		document on the eMAR if a				
		dications to take out of the				
		dications to take out of the				
	facility.	delivered medications, the				
		delivered medications, the				
		ecked in before placing on				
	the medication cart.					
		cation was not on the cart				
		eass, the medication was				
		on the eMAR because it was				
	still in the pharmacy of	crate.				
	-	interview on 08/18/19 at				
	9:48 am with a third N	AA was unsuccessful.				
	Observation on 08/14	19 at 10:45 am of resident				
	#2 revealed she was	wearing a brace on her left				
	lower arm.					
	Interview on 08/15/19	at 10:45 am with Resident				
	#2 revealed:					
		fractured wrist and wore a				
	brace on her left wrist					
		iplications, her arm was not				
		not able to remove the				

brace.

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STATE FORM 6899 0N4H11 If continuation sheet 49 of 73

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
ANDILAN	or dortheorion	IDENTIFICATION NOMBER.	A. BUILDING: _	<del></del>		
		HAL053028	B. WING		08/16	6/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING	1107 CART	HAGE STREE	т		
		SANFORD	, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page 49		D 358			
	-Her primary care phy three times a day for -When she was not gi in pain and "had the s-Sometimes "staff did of the pharmacy crate Interview on 08/15/19 #2's family member re-The facility did not not had missed her pain re-She would have beet taking the Tramadol.  Interview on 08/15/19 contracted Pharmacis -If an order for a med pm - 3:00 pm, it would the same day, if after would be delivered the The Pharmacist coultimes of requested on she could access the -Tramadol 50 mg, 90 delivered to the facility -The number delivered needed for 3 doses for The Pharmacist did remissed the doses of The missed the doses of The Pharmacist did remissed the do	vsician ordered Tramadol pain. iven the Tramadol, she was shakes and hurt all over." not take the (Tramadol) out and administer it to me."  at 4:25 pm with Resident evealed: otify him that Resident #2 medication. In in a lot of pain without  at 3:30 pm with the st revealed: ication was ordered by 2:00 db e delivered to the facility 3:00 pm, the medication e next day. d not verify the dates and ders 30 days or more back; delivery dates. tablets for Resident #2 were y on 06/10/19. tablets for Resident #2 were				
	care provider (PCP) fr -Tramadol 50 mg thre for Resident #2 for pa -She had not been no been receiving Trama	tified Resident #2 had not				

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STATE FORM 6899 0N4H11 If continuation sheet 50 of 73

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_		R	
		HAL053028	B. WING		08/16/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		HAGE STREE	т		
		SANFORD,	NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	Ξ
D 358	Continued From page	<del>2</del> 50	D 358			
	Tramadol to get the re not healing and possi	esident through a period of ble surgery.				
		n a representative from the armacy 08/15/19 at 8:50 am.				
	Refer to interview with 12:22 pm.	n the MA on 08/15/19 at				
	Refer to interview with 08/15/19 at 4:20 pm a	n the Administrator on and 08/16/19 at 12:40 pm.				
	Refer to interview with 4:46 pm and 08/16/19	n the RCC on 08/15/19 at 9 at 12:30 pm.				
	Refer to interview with 08/16/19 at 11:20 am					
	Interview with a repre contracted pharmacy revealed:	sentative from the facility 08/15/19 at 8:50 am				
	prior to July 2019.	n refills were on a cycle fill				
	facility every month w to reorder.	ons were delivered to the ithout the facility staff having				
	of each month.	cations started on the 28th quested medications to be				
	called as needed inste	ead of cycle filled. y the Administrator				
	cycle filled to call as r					
	medications within the	ded to call and request e last 10 doses so there was				
	no lapse in medication -The medications order	n administration. ered would be delivered to				
	the facility the same of	lay unless the medication and then delivery would take				

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STATE FORM 6899 0N4H11 If continuation sheet 51 of 73

DIVISION	of fleatin Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						,
		UAL 052020	B. WING		F	
		HAL053028	1		08/1	16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		1107 CAR	THAGE STREE	т		
ROYAL O	AKS ASSISTED LIVING	SANFORD	, NC 27350			
()(4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTIO		(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
D 358	Continued From page	51	D 358			
D 000	Continued From page 51		5 000			
		hould have included enough				
	medication to last thro	ough the end of July 2019.				
	-The medication labels are the billed date and not					
	the dispense date.					
	Interview with the me					
	08/15/19 at 12:22 pm					
	-The MAs were respo	nsible for ordering				
	medication.					
	-If the medication order was "rejected" by the					
		leave a note for the next				
	shift.					
	-She was recently tau					
	_	the electronic Medication				
	Administration Record					
		was requested from the				
	•	ecked when the medication				
		acility by the pharmacy.				
	-She did not know wh	o was responsible for				
	completing record, ell					
	-She did not know wh	en record, eMAR, and cart				
	audits were complete	d.				
		ninistrator on 08/15/19 at				
	4:20 pm revealed:					
	-The facility requested					
		contracted pharmacy on				
	07/31/19.					
		I cycle filled and September				
		st month of call as needed				
	orders.					
		armacy orders from cycle				
	filled to call as needed	d because the medications				
	were delivered at vari	ous times and she wanted				
	more control on who	was receiving the				[
	medications at the fac	cility.				
		nsible for sending FL2s to				
	the pharmacy.	-				
		nsible for performing weekly				

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electronic Medication Administration Record

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL053028	B. WING		08/16/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
			HAGE STREE			
ROYAL O	AKS ASSISTED LIVING		NC 27350	•		
			140 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page 52		D 358			
	(eMAR) and cart audits.  -The eMAR and cart audits were random and should have included the bulk of the cart.  -Medications received from the pharmacy should be verified by the working MA.					
	,	the RCC if the medication				
	was not received the					
	-She expected the M/ medications if it was r					
	inedications in it was i	iot received.				
	(RCC) on 08/15/19 at -The RCC was respon Medication Administra cart audits.	nsible for electronic ation Record (eMAR) and one eMAR and cart audit				
	on 08/16/19 at 11:20 -Medications from 07/ cycle fillThe MA was respons	/28/19 to 08/01/19 were on a sible for ordering the electronic Medication				
	delivered from the ph -If the medication was call the pharmacy and AdministratorWhen a medication r	s not delivered, she would d then notify the ran out or was in the last 10				
	eMARWhen she selected " from pharmacy" this r through the eMAR an or close to being out ( -The medications wer	e an order through the  med (medication) on order meant she placed an order id the medications were out (in the last 10 days). The administered when she er from pharmacy" in the				

eMAR.

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1107 CARTHAGE STREET  SANFORD, NC 27350  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
ROYAL OAKS ASSISTED LIVING    CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   CEACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   D 358   Continued From page 53   D 358   -If medications were not administered, for any reason, she would notify administration and the provider the same day.   -She would document on the eMAR when a provider was notified.   -The RCC and Administrator were responsible for eMAR and cart audits.   -The RCC and Administrator completed audits   -The RC			HAL053028	B. WING		08	R 8/ <b>16/2019</b>
ROYAL OAKS ASSISTED LIVING  (X4) ID PREFIX TAG  TAG  CONTINUED FROM PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 53  -If medications were not administered, for any reason, she would notify administration and the provider the same dayShe would document on the eMAR when a provider was notifiedThe RCC and Administrator were responsible for eMAR and cart auditsThe RCC and Administrator completed audits	NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE	•	
SANFORD, NC 27350  (X4) ID PREFIX TAG    CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   D 358   D 358	ROYAL O	AKS ASSISTED I IVING	1107 CAF	RTHAGE STREET			
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 53  -If medications were not administered, for any reason, she would notify administration and the provider the same dayShe would document on the eMAR when a provider was notifiedThe RCC and Administrator were responsible for eMAR and cart auditsThe RCC and Administrator completed audits	KOTALO	AND ADDIOTED LIVING	SANFOR	D, NC 27350			
-If medications were not administered, for any reason, she would notify administration and the provider the same dayShe would document on the eMAR when a provider was notifiedThe RCC and Administrator were responsible for eMAR and cart auditsThe RCC and Administrator completed audits	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Interview with the RCC on 08/16/19 at 12:30 pm revealed:  -When "med (medication) on order from pharmacy" was selected on the eMAR, this meant the medication was ordered and waiting to be brought by the pharmacy.  -The medication was not at the facility when "med on order from pharmacy" was selected on the eMAR.  Interview with the Administrator on 08/16/19 at 12:40 pm revealed:  -When "med (medication) on order from pharmacy" was selected on the eMAR, this meant the medication was ordered and waiting to arrive.  -The medication was out and not at the facility when "med on order from pharmacy" was selected on the eMAR.  The facility failed to administer medications as ordered for 2 of 3 residents (#1 and #2), including an antiretroviral antibiotic, an anti-hypertensive resulting in elevated blood pressure (hypertension), an anticholinergic, anti-anxiety medications resulting in increased levels of anxiety and sleep disturbances (#1), and a pain medication which could cause increased levels of	D 358	-If medications were reason, she would no provider the same da -She would documer provider was notified -The RCC and Admin eMAR and cart audit -The RCC and Admin monthly and with new Interview with the RC revealed: -When "med (medication was obrought by the pharm -The medication was on order from pharm eMAR.  Interview with the Ad 12:40 pm revealed: -When "med (medication was on order from pharm eMAR.  Interview with the Ad 12:40 pm revealed: -When "med (medication was on order from pharm eMAR.  Interview with the Ad 12:40 pm revealed: -When "med (medication was on order from pharm eMAR.  The facility failed to a ordered for 2 of 3 resulting in elevated (hypertension), an an medications resulting anxiety and sleep dispersions.	not administered, for any orify administration and the ay. In on the eMAR when a Inistrator were responsible for s Inistrator completed audits worders.  Inistrator on 08/16/19 at 12:30 pm attention on order from cred on the eMAR, this meant ordered and waiting to be accy.  In not at the facility when "med acy" was selected on the emacy.  Initiation on order from cred on the eMAR, this meant ordered and waiting to arrive.  In out and not at the facility from pharmacy" was readminister medications as sidents (#1 and #2), including protic, an anti-hypertensive blood pressure enticholinergic, anti-anxiety grin increased levels of sturbances (#1), and a pain	D 358	DETIGEN		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN C	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPLETED
		HAL053028	B. WING		R 08/16/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
ROYAL O	AKS ASSISTED LIVING	1107 CAR	THAGE STREE	т	
		SANFORD	, NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 54	D 358		
	this violation.  CORRECTION DATE	131D-34 on 08/16/19 for			
D 375	10A NCAC 13F .1005 Medications	5(a) Self-Administration Of	D 375		
	10A NCAC 13F .1005 Self -Administration Of Medications  (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:  (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and  (2) specific instructions for administration of prescription medications are printed on the medication label.				
	interviews, the facility sampled residents (#	as evidenced by: as, record reviews, and failed to assure 1 of 3 1) had physicians' orders to we drops, an inhaler, and a			
	The findings are:				
	Review of Resident #	1's current FL2 dated			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7442 1 2744	or contraction	BENTI IO/MIGNATION	A. BUILDING: _	<del></del>	
		HAL053028	B. WING		R 08/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
POVAL O	AKS ASSISTED LIVING	1107 CAR	THAGE STREE	т	
ROTALO	ANS ASSISTED LIVING	SANFORD	, NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETE
D 375	02/26/19 revealed: -Diagnoses included disease, chronic obst vitamin D deficiency, and hyperlipidemiaThe resident was am assistance with bathin Review of Resident # revealed: -The resident used a -The resident required of daily living tasks of dressing, grooming, a -The resident required ambulation and transinal a. Review of Residen 02/26/19 revealed: -There was an order to used to treat open-and	a blood borne pathogen ructive pulmonary disease, depression, failure to thrive, abulatory and required and and dressing.  1's care plan dated 11/16/18 walker at times to ambulate. It is supervision with activities eating, toileting, bathing, and transferring.	D 375		
	02/14/19 revealed an instill 1 drop into both Review of Resident # physician's order to s 0.1%.  Observation of Residhand (kept in his roor revealed: -The alphagan 0.1% kept in Resident #1's -There were two 5 ml	1's physician's orders dated order for alphagan 0.1%,			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL053028	B. WING		R
		HAL093026			08/16/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	
20141		1107 CAF	RTHAGE STREET	Г	
ROYAL O	AKS ASSISTED LIVING	SANFOR	D, NC 27350		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	\ - /
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
TAG	REGOLATOR OR E	iso is a real firm of the control of	TAG	DEFICIENCY)	W. (12
5.0==			D 0==		
D 375	Continued From page	e 56	D 375		
	03/21/19 (open).				
	Review of Resident #	1's June 2019 electronic			
	medication administra	ation records (eMARs)			
	revealed:				
	-	or alphagan 0.1%, instill 1			
		vice a day scheduled at 8:00			
	am and 7:00 pm.				
	-Alphagan 0.1% was				
		/01/19 through 06/30/19.			
		nentation on the eMAR			
	indicating the alphaga	an 0.1% was self			
	administered.				
	Review of Resident #	1's July 2010 aMAPs			
	revealed:	13 July 2013 CMARTS			
		or alphagan 0.1%, instill 1			
	_	vice a day scheduled at 8:00			
	am and 7:00 pm.				
	-Alphagan 0.1% was	documented as			
		/01/19 through 07/23/19,			
	07/24/19 at 7:00 pm t	hrough 07/28/19 at 8:00 am,			
	07/29/19 at 7:00 pm,	and 07/31/19 at 7:00 pm.			
	-Alphagan 0.1% was				
		4/19 at 8:00 am due to			
	Resident #1 was "out	of facility" for an			
	appointment.				
	-Alphagan 0.1% was				
		8/19 at 7:00 pm, 07/29/19 at 7:00 pm due to the "med on			
	order from pharmacy				
	-Alphagan 0.1% was				
	administered on 07/30				
		due to the medication was			
	"not on cart".	ade to the inculcation was			
		nentation on the eMAR			
	indicating the alphaga				

administered.

Review of Resident #1's August 2019 eMARs

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		HAL053028	B. WING		R 08/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
BOYAL O	AKS ASSISTED LIVING	1107 CAF	RTHAGE STREE	г	
ROTAL O	ANS ASSISTED LIVING	SANFOR	D, NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 375	Continued From page 57		D 375		
	from 08/01/19 through -There was an entry f drop into both eyes tw am and 7:00 pmAlphagan 0.1% was administered from 08/ except on 08/01/19 at 7:00 pm due to the m -There was no docum indicating the alphaga administered.  Interview with Reside pm revealed: -He applied alphagan morning to both eyes.	th 08/15/19 revealed: for alphagan 0.1%, instill 1 vice a day scheduled at 8:00  documented as /01/19 through 08/15/19 t 8:00 am and 08/05/19 at edication was "not on cart". hentation on the eMAR an 0.1% was self  int #1 on 08/15/19 at 12:45 in 0.1% drops, 1 drop every			
	drops in his roomShe did not know Re administering the alph prescribedShe did not know Re order to self administersShe documented alpadministered.  Interview with a reprecontracted pharmacy revealed: -There was no self adalphagan 0.1% drops -A 30-day supply of a dispensed on 03/21/1	revealed: #1 kept the alphagan 0.1% esident #1 was not hagan 0.1% drops as esident #1 did not have an er the alphagan 0.1% drops. Shagan 0.1% drops were esentative from the on 08/15/19 at 8:52 am dminister order for the libragan 0.1% drops was			

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out of alphagan 0.1% drops on 04/21/19.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 30 <u>-</u>		R
		HAL053028	B. WING		08/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE	
ROYAL O	AKS ASSISTED LIVING		RTHAGE STREE	т	
0(4) ID	SHIMMADV STA	ATEMENT OF DEFICIENCIES	D, NC 27350	PROVIDER'S PLAN OF CORRECTION	l (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 375	Continued From page	e 58	D 375		
	-The facility requested a refill for alphagan 0.1% on 07/28/19A 30-day supply of alphagan 0.1% drops was dispensed on 07/29/19.				
	provider on 08/16/19 -The alphagan 0.1% of glaucomaThe alphagan 0.1% of eyes twice a dayResident #1 was last pressure was not increment of the provider did not administering the alphagan drops as or Refer to interview with 12:45 pm.	know the resident was self nagan 0.1% eye drops. ed staff to administer dered.  n Resident #1 on 08/15/19 at na medication aide (MA) on			
	Refer to interview with contracted pharmacy	n a representative from the on 08/15/19 at 8:52 am.			
	Refer to interview with Coordinator on 08/16.				
	Refer to interview with 08/16/19 at 12:40 pm	n the Administrator on			
	02/26/19 revealed the	a medication used to treat			
	Review of Resident #	1's subsequent physician's			

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orders dated 04/25/19 revealed an order for

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL053028	B. WING		08	R 8/16/2019
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	F ZIP CODE	1 00	
TO AVIL OF T	NOVIDEN ON OUT FIELD		RTHAGE STREET			
ROYAL O	AKS ASSISTED LIVING		D, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 375	Continued From page	e 59	D 375			
	latanoprost 0.005% e both eyes at bedtime.	ye drops, instill 1 drop into				
	Review of Resident #1's record revealed no physician's order to self administer latanoprost 0.005%.					
	hand (kept in his room revealed: -The latanoprost 0.00 available and kept in -There was 1 unopen	Resident #1's bedside table.				
	medication administrative revealed: -There was an entry for drops instill 1 drop int scheduled at 8:00 pm -Latanoprost 0.005% as administered from -There was no docum	1's June 2019 electronic ation records (eMARs) for latanoprost 0.005% eye to both eyes at bedtime in eye drops was documented 06/01/19 through 06/30/19. Intentation on the eMAR 0.005% eye drops were self				
	drops, instill 1 drop in scheduled at 8:00 pm -Latanoprost 0.005% as administered from at 8:00 pmStaff documented lat was not administered	for latanoprost 0.005% eye to both eyes at bedtime i. eye drops was documented 07/01/19 through 07/27/19 canoprost 0.005% eye drops				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			,
		HAL053028	B. WING		08/1	6/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		THAGE STREE	т		
		SANFORE	), NC 27350		Т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 375	Continued From page	e 60	D 375			
	-There was no documentation on the eMAR indicating latanoprost 0.005% eye drops were self administered.					
	from 08/01/19 through -There was an entry for drops, instill 1 drop in scheduled at 8:00 pm -Latanoprost 0.005% as administered from at 8:00 pmStaff documented lat was not administered to the medication was -There was no documindicating latanoprost administered.  Interview with Reside pm revealed: -He was not self adm 0.005% eye drops.	for latanoprost 0.005% eye to both eyes at bedtime in eye drops was documented 08/01/19 through 08/15/19 anoprost 0.005% eye drops on 08/06/19 at 8:00 pm due is "not on cart". In the entation on the eMAR 0.005% eye drops were self in the anoprost on 08/15/19 at 12:45 in istering latanoprost ost eye drops were the same				
	Interview with a medio 08/16/19 at 11:20 am -She did not know Relatanoprost 0.005% e -She did not know Readministering latanop prescribedShe did not know Reorder to self administed dropsShe did not know the drops were not on the	cation aide (MA) on revealed: esident #1 kept the ye drops in his room. esident #1 was not crost 0.005% eye drops as esident #1 did not have an er latanoprost 0.005% eye				

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were administered.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		HAL053028	B. WING		08/16/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		THAGE STREE	т		
040.45	CLIMMADV CT		, NC 27350	DDOVIDED'S DI AN OF CODDECTION	1 075	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 375	Continued From page	e 61	D 375			
	revealed: -There was no self ad latanoprost 0.005% e -A 30-day supply (2.5 eye drops was disper -If given as ordered R out of latanoprost 0.0 -The facility requested 0.005% eye drops on -A 30-day supply (2.5 eye drops was disper Telephone interview was provider on 08/16/19 -Latanoprost 0.005% for mild glaucomaLatanoprost 0.005% drop into both eyes at -Resident #1 was last pressure was not incr-The provider did not administering latanop Refer to interview with 12:45 pm.  Refer to interview with 08/16/19 at 11:20 am	Iminister order for the ye drops. Iminister order for the ye drops. Imi) of latanoprost 0.005% ased on 04/26/19. It is				
	Refer to interview with	n the Administrator on				

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08/16/19 at 12:40 pm.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL053028	HAL053028 B. WING		08/16/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ROYAL OAKS ASSISTED LIVING 1107 CAP			HAGE STREE	т	
ROTAL O	ANS ASSISTED LIVING	SANFORD,	NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 375	Continued From page	e 62	D 375		
	02/26/19 revealed the Ipratropium/Albuterol chronic obstructive pure Review of Resident # orders dated 02/14/18 Ipratropium/Albuterol vial via nebulizer ever shortness of breath.  Review of Resident # physician's order to sel Ipratropium/Albuterol.  Observation of Resident # physician's order to sel Ipratropium/Albuterol.  Observation of Resident # order in Reside	(a medication used to treat ulmonary disease).  1's previous physician's or revealed an order for 0.5-3(2.5) mg/3 ml, use 1 my 6 hours as needed for  1's record revealed no elf administer  ent #1's medications on mn) on 08/15/19 at 10:30 am  uterol 0.5-3(2.5) mg/3 ml of in a plastic storage #1's room.  ml) vials of 0.5-3(2.5) mg/3 ml labeled th 45 remaining.  er machine located in mn the bedside table.  1's June 2019 electronic ation record (eMAR)  for Ipratropium/Albuterol se 1 vial via nebulizer every			
	-There was no docum	nentation on the eMAR pium/Albuterol 0.5-3(2.5)			

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				COMPLETED
		7. BOILBING.		R
	HAL053028	B. WING		08/16/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
	1107 CART	HAGE STREE	т	
ROYAL OAKS ASSISTED LIVING	SANFORD	NC 27350		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 375 Continued From page 63		D 375		
Review of Resident #1's J revealed:  -There was an entry for Ip 0.5-3(2.5) mg/3 ml, use 1 6 hours as needed for she Ipratropium/Albuterol 0.5-documented as administe  -There was no documental indicating the Ipratropium/mg/3 ml was self administe.  Review of Resident #1's A 08/01/19 through 08/15/19  -There was an entry for Ip 0.5-3(2.5) mg/3 ml, use 1 6 hours as needed for she Ipratropium/Albuterol 0.5-documented as administe.  There was no documental indicating the Ipratropium/mg/3 ml was self administ.  Interview with Resident #1 pm revealed:  -He administered the Ipratimes a day as needed for He experienced shortnes.  He had been without the least one month.  Interview with a medication 08/16/19 at 11:20 am revealed:  -She knew Resident #1 ke Ipratropium/Albuterol in hiles -She did not know Reside order to self administer the Interview with a represent.	pratropium/Albuterol vial via nebulizer every portness of breath3(2.5) mg/3 ml was not pred for July 2019. ation on the eMAR /Albuterol 0.5-3(2.5) tered.  August 2019 eMAR from 9 revealed: pratropium/Albuterol vial via nebulizer every portness of breath3(2.5) mg/3 ml was not pred for August 2019. ation on the eMAR /Albuterol 0.5-3(2.5) tered.  1 on 08/15/19 at 12:45 tropium/Albuterol 3 r shortness of breath. as of breath daily. Ipratropium/Albuterol at  on aide (MA) on ealed: ept the is room. ent #1 did not have an e Ipratropium/Albuterol.	D 375		

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revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
	HAL053028 B. WING			08/16/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE	
			HAGE STREE		
ROYAL OAKS ASSISTED LIVING			, NC 27350	•	
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 375	Continued From page	e 64	D 375		
	-There was no self ac Ipratropium/Albuterol -A 30-day supply of Ip 0.5-3(2.5) mg/3 ml wa and 08/08/19The label for Ipratropmg/3 ml on 01/17/19 medication was billed  Telephone interview w Care Provider (PCP) revealed: -Resident #1 was last -The Ipratropium/Albuchronic obstructive pu-She had never obserbreath.	dminister order for the 0.5-3(2.5) mg/3 ml. oratropium/Albuterol as dispensed on 02/11/19 oium/Albuterol 0.5-3(2.5) refers to the date the l. with Resident #1's Primary on 08/16/19 at 11:07 am			
	Refer to interview with 12:45 pm.	h Resident #1 on 08/15/19 at			
	•	h a medication aide (MA) on			
		h a representative from the on 08/15/19 at 8:52 am.			
	Refer to interview with Coordinator on 08/16				
	Refer to interview with 08/16/19 at 12:40 pm	h the Administrator on			
	02/26/19 revealed the	t #1's current FL2 dated ere was no order for Ventolin o treat chronic obstructive			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL053028	B. WING		08	R 8/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		RTHAGE STREET			
	T	SANFOR	RD, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 375	Continued From page	e 65	D 375			
	orders dated 02/14/19 -There was an order finhale 2 puffs 4 times wheezing.	for Ventolin 90 mcg inhaler,				
		1's record revealed no lent #1 to self administer				
	Observation of Resident #1's medications on hand (kept in his room) on 08/15/19 at 10:30 am revealed there was 1 empty Ventolin inhaler located in Resident #1's rollator walker.					
	Review of Resident # medication administrative revealed:	1's June 2019 electronic ation record (eMAR)				
	revealed: -There was an entry for Ventolin 90 mcg inhale 2 puffs 4 times a day as needed for wheezing (may keep at bedside and self administer)Ventolin 90 mcg was not documented as administered for June 2019.					
		for Ventolin 90 mcg inhale 2 s needed for wheezing (may self administer).				
	08/01/19 through 08/ -There was an entry f	or Ventolin 90 mcg inhale 2 s needed for wheezing (may self administer).				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		
					R	
		HAL053028	B. WING		08/16/2019	
		IIAE000020			1 00/10/2013	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
DOVAL O	AVE ACCICTED I IVING	1107 CAF	RTHAGE STREE	т		
RUTAL O	AKS ASSISTED LIVING	SANFOR	D, NC 27350			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	V (X5)	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLET	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	
			_	,		
D 375	Continued From page	e 66	D 375			
	administered for Augu	ust 2010				
	auministered for Augu	ust 2019.				
	Interview with Reside	ent #1 on 08/15/19 at 12:45				
	pm revealed:					
	•	Ventolin 2 puffs 5-6 times a				
	day as needed for sh					
	•	t Ventolin for at least 1				
	month.					
	-He told staff he was	out of Ventolin (date				
	unknown).	·				
	Interview with a medi-	cation aide (MA) on				
	08/16/19 at 11:20 am	revealed:				
	-She knew Resident a	#1 kept the Ventolin in his				
	room.					
		esident #1 did not have a				
		administer the Ventolin 90				
	mcg.					
		oposed to tell staff when he				
	needed Ventolin refille	told her he was out of				
	Ventolin.	told her he was out of				
	VOITOIIII.					
	Interview with a repre	esentative from the				
		on 08/15/19 at 8:52 am				
	revealed:					
		for Ventolin to be kept at the				
	bedside and self adm					
		n inhaler dispensed on				
	05/06/19 and 06/03/1	•				
	Telephone interview v	with Resident #1's Primary				
		on 08/16/19 at 11:07 am				
	revealed:					
	-Resident #1 was last					
	-The Ventolin was pre					
		rved Resident #1 short of				
	broath		1			

-If Ventolin was not available Resident #1 was at an increased risk for a COPD exacerbation and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL 052029	B. WING		0.0	R
		HAL053028			08	3/16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		RTHAGE STREET	•		
		SANFOR	D, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 375	Continued From page	e 67	D 375			
	shortness of breathShe did not know Ve	ntolin was not available.				
	Refer to interview with 12:45 pm.	n Resident #1 on 08/15/19 at				
	Refer to interview with a medication aide (MA) on 08/16/19 at 11:20 am.					
		n a representative from the on 08/15/19 at 8:52 am.				
	Refer to interview with the Resident Care Coordinator on 08/16/19 at 12:30 pm.					
	Refer to interview with 08/16/19 at 12:40 pm	n the Administrator on				
	Interview with Reside pm.	nt #1 on 08/15/19 at 12:45				
	to be in a locked cabi	ne medications in his room				
	to make sure he had	enough available.				
	perform an assessme	revealed: e facility was required to ent on Resident #1 to				
	evaluate competency medicationsWhen she administer	to self administer red medications for her shift				
	she would ask Reside self administered med	ent #1 if he had taken his dications.				
		he medications stored in make sure they were				
		told her he was out of any				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		_	,
		HAL053028	B. WING		08/1	6/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING	1107 CART	HAGE STREE	т		
- KOTAL O	AND ADDID EIVING	SANFORD,	NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 375	Continued From page	÷ 68	D 375			
	eMAR but the note dimedication was not at -She had not observe shortness of breathShe did not know the #1's room were supposecure.  Interview with a reprecontracted pharmacy revealed: -The residents' medic prior to July 2019The facility staff now	nedications from the document a note on the d not indicate the vailable.  ad Resident #1 experience a medications in Resident osed to be locked and assentative from the on 08/15/19 at 8:52 am acations were on cycle fill				
	08/16/19 at 12:30 pm -She did not know sel were to be lockedShe did not know Re medications in July ar -She did not know if a completed for Reside medicationsShe did not know Re in his room without a -The MA/RCC was re medications.  Interview with the Adr 12:40 pmResident #1 had not medications.	If administered medications esident #1 went without and August 2019. an assessment was ant #1 to self-administer esident #1 had medications				

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medications.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL053028	B. WING		08	R 3/ <b>16/2019</b>
	ROVIDER OR SUPPLIER  AKS ASSISTED LIVING	1107 CA	DDRESS, CITY, STATE RTHAGE STREET RD, NC 27350	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 375	kept in Resident #1's -She did not know if s in Resident #1's room -She did not know the Resident #1's room w administerTo her knowledge sta	If administered medications room needed to be locked. staff monitored medications n. ere were medications in with no order to self aff did not complete an dent #1 to evaluate his ability	D 375			
D912	G.S. 131D-21 Declar Every resident shall h 2. To receive care an adequate, appropriate	laration of Residents' Rights ration of Residents' Rights have the following rights: and services which are e, and in compliance with state laws and rules and	D912			
	reviews, the facility fa received care and ser appropriate, and in co	ns, interviews, and record illed to ensure residents rvices which were adequate, ompliance with relevant is and rules and regulations d food service and				
	interviews, the facility	ions, record reviews and failed to assure therapeutic ordered for 2 of 5 sampled				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL053028	B. WING		80	R / <b>16/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		RTHAGE STREET D, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D912	(MS) diet with nectar and nutritional supple to Tag 0310, 10A NC, and Food Service (Ty  2. Based on observareviews, the facility fawere administered as prescribing practitioneresidents (#1 and #2) medications, 2 anti-hyanticholinergic medic (Resident #1), and 1 #2). [Refer to Tag 03	ders for a mechanical soft thick liquids (Resident #4) ments (Resident #1). [Refer AC 13F .0904(e)(4) Nutrition rpe B Violation)]. tions, interviews, and record iled to assure medications ordered by a licensed	D912			
D992	G.S. § 131D-45. Example the presence of control for applicants for emphomes.  (a) An offer of employ licensed under this Acconditioned on the apexamination and screen substances. The example conducted in acconducted	ment by an adult care home ticle to an applicant is plicant's consent to an	D992			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 50.25			R
		HAL053028	B. WING			16/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		THAGE STREE ), NC 27350	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D992	controlled substance examination and scre physician to treat the psychological condition physician shall includ substance, the prescribed and the condition for prescribed. If the result employee's examinat the presence of a concare home may requi	g physician that every identified by the ening is prescribed by that applicant's medical or on. The verification from the e the name of the controlled ribed dosage and frequency, which the substance is all of an applicant's or ion and screening indicates attrolled substance, the adult are a second examination by the results of the prior	D992			
	This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure documentation of an examination and screening for the presence of controlled substances was completed for 1 of 3 sampled staff (Staff C) prior to hire.  The findings are:  Review of Staff C's, medication aide personnel record revealed: -Staff C was hired on 04/12/17There was no documentation Staff A had completed the examination and screening for the presence of controlled substanceThere was no consent for a controlled substance examination and screening.  Interview with Staff C on 08/16/19 at 1:31pm					
	Interview with Staff C revealed:	on 08/16/19 at 1:31pm				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R		
		HAL053028	B. WING		08/1	6/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ESS, CITY, STATE, ZIP CODE			
ROYAL OAKS ASSISTED LIVING 1107 CARTHAGE STREET							
SANFORD, NC 27350							
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
D992	Continued From page 72		D992				
	REGULATORY OR LSC IDENTIFYING INFORMATION)						

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