Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C
		HAL073019	B. WING		07/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
DOVDOD!	A SSISTED LIVING ODG	5660 DUI	RHAM ROAD		
ROXBOR	O ASSISTED LIVING OPC	ROXBOF	RO, NC 27574		
(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 000	D 000 Initial Comments		D 000		
	_	sure Section conducted a a complaint investigation 24.			
D 139	10A NCAC 13F .0407 Qualifications	(a)(7) Other Staff	D 139		
	(a) Each staff person (7) have a criminal ba in accordance with G.	Other Staff Qualifications at an adult care home shall: ckground check completed S. 131D-40 and results person's personnel file;			
	This Rule is not met a	as evidenced by: ETYPE B VIOLATION			
	Based on these findin Violation was not aba	gs, the previous Type B ted.			
	facility failed to ensure	ews and interviews, the e 2 of 6 sampled staff (A and kground check completed			
	The findings are:				
	personnel record reversely extended to personnel record reversely extended to the control of the	06/01/24. I consent for a criminal mentation of a criminal ing completed.			
	revealed: -She signed a consen	on 07/10/24 at 3:54pm at to have a criminal ne when she was hired and			

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		
		HAL073019	B. WING		R-C <b>07/10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ROXBOR	O ASSISTED LIVING OPC	CO LLC	HAM ROAD D, NC 27574		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	\ -/
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
D 139	Continued From page	e 1	D 139		
	background checkShe went to the cour	ity completed the criminal thouse and paid to have a check done because the se one for her.			
	background check.				
	Interview with the Assistant to the Administrator on 07/10/24 at 3:58pm revealed: -She called the company the facility used to conduct criminal background checks to obtain copies but there was no evidence Staff A had a criminal background check completed with that companyShe did not have Staff A sign a consent to have criminal background checks completed.				
	of Operations on 07/1	ministrator/Regional Director 10/24 at 4:30pm revealed: ninal background check for			
	Staff AStaff A started after the previous Administrator left and her criminal background check did not get completedThe previous Administrator left the facility in May 2024.				
		s with the Assistant to the 8/24 at 4:17pm and on			
	Refer to the interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:30pm.				
	2. Review of Staff B's personnel record reve-Staff B was hired on				

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Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		1141.070040	B. WING		R-C
		HAL073019	B. W		07/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, STA	TE, ZIP CODE	
		5660	DURHAM ROAD		
ROXBORO ASSISTED LIVING OPCO LLC		BORO, NC 27574			
			DORO, NO 27374	T	
(X4) ID		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 100		_	5.400		
D 139	Continued From page	e 2	D 139		
	-There was a signed	consent for a criminal			
	background check.				
	•	nentation of a criminal			
	background check be				
	5.00.1.g. 5.00.1.g. 5.1.5011.55	gp			
	Interview with a Staff	B on 07/09/24 at 4:11am			
	revealed:				
	-She had worked at the	he facility for about three			
	months.				
		d by the Assistant to the			
		ut a consent for a criminal			
	background check thi				
	-	to fill out the third one			
	today, 07/09/24.				
	today, 07700/24.				
	Interview with the Ass	sistant to the Administrator			
	on 07/10/24 at 3:58pr				
	Tell control of the c	pany the facility used to			
	-	kground checks to obtain			
		no evidence Staff B had a			
		check completed with that			
	company.	oneok completed with that			
		aff B sign a consent to have			
	criminal background	_			
	omminar baokground v	oncoka completed.			
	Interview with the Adr	ministrator/Regional Director			
		10/24 at 4:30pm revealed:			
	· · · · · · · · · · · · · · · · · · ·	ninal background check for			
	Staff B.	inia. Buonground oncon 101			
		en a billing issue when Staff			
		and check was completed.			
	2 3 Gillinai baongrou	ana onook was completed.			
	Refer to the interview	s with the Assistant to the			
		08/24 at 4:17pm and on			
	07/10/24 at 3:58pm.	55,2 Fac 1. 17 pin and on			
	01/10/27 at 0.00pm.				
	Refer to the interview	, with the			
		al Director of Operations on			
	07/10/24 at 4:30pm.	a. D. Octor of Operations on			
	2., . 0, = . at 1.00piii.		1	I .	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HAL073019		B. WING	B. WING		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	07/10/2024
ROXBORG	ASSISTED LIVING OPC	CO LLC	RHAM ROAD RO, NC 27574		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETE
D 139	on 07/08/24 at 4:17pr -She was promoted in Administrator's position Administrator/Regions when the previous Addin the middle of May 2-She had not had any Resident Care Coordinar learn what needed Interview with the Asson 07/10/24 at 3:58pr -The previous Administratory at 3:58pr -The previou	sistant to the Administrator in revealed: Into the Assistant to the con by the cal Director of Operations Iministrator left the position 2024. If training for the position; the inator (RCC) was helping in to be done.  Sistant to the Administrator in revealed: Instrator conducted criminal cut she no longer worked at a sible for completing criminal in new employees. Insonnel records.  Insider the Administrator in revealed checks should be completed the beginning work.  Insure criminal background ed for Staff A and Staff B, in facility, resulting in the call the staff had a criminal cas detrimental to the health, if the residents and the test of the staff had a criminal cased Type B Violation.	D 139		
D 182	10A NCAC 13F .0602 Facilities with a Capa	· ·	D 182		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILANC	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		
		HAL073019	B. WING		R-C 07/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
ROXBORO	ASSISTED LIVING OPC	CO LLC	HAM ROAD		
	OUN MAN DV OT		), NC 27574		
(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 182	Continued From page	· 4	D 182		
	10A NCAC 13F .0602 Management Of Facilities With A Capacity Or Census Of 31 To 80 Residents  (b) When the administrator is not on duty in the				
	facility, there shall be a person designated as administrator-in-charge on duty in the facility who has the responsibility for the overall operation of the facility and meets the qualifications for administrator-in-charge required in Rule .0602 of this Section. The personal care aide supervisor, as required in Rule .0605 of this Subchapter, may serve simultaneously as the				
	administrator-in-charge.  This Rule is not met as evidenced by:				
	TYPE B VIOLATION  Based on observations, interviews, and record reviews, the Administrator failed to ensure the Administrator-in-Charge was qualified and trained to be in charge of the overall operations of the facility.				
	The findings are:				
	The findings are:  Observations of the facility on 07/08/24 from 9:30am to 5:00pm revealed only the Assistant to the Administrator was in the building; the Administrator/Regional Director of Operations and the Resident Care Coordinator (RCC) were not in the facility.				

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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	
						R-C
		HAL073019	B. WING			/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ROXBOR	O ASSISTED LIVING OP	CO LLC	RHAM ROAD 30, NC 27574			
0.0.1=	CLIMMADV CT	ATEMENT OF DEFICIENCIES	·	DDOVIDEDIS DI ANG	OF CORRECTION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 182	2 Continued From page 5		D 182			
	7:30am to 5:15pm reThe Assistant to the to transport residents appointments around around 2:00pmThe Administrator/Re- Operations was on a approximately 11:00aAt 12:30pm, the RC- Administrator/Region come to the front desThe survey team wa facility staff told the R- Administrator/Region had left the facilityThe survey team did	Administrator left the facility to their physicians' 9:30am and returned egional Director of cell phone in an office at am. C requested the al Director of Operations to k on the intercom system. ited for five minutes before a				
	Observations of the facility on 07/10/24 from 8:00am to 6:00pm revealed the Administrator/Regional Director of Operations arrived at the facility at around 2:00pm and was there until the survey team exited at 6:00pm.  Review of the Assistant to the Administrator's personnel record revealed: -She was hired on 11/24/20 as the front desk receptionistThere was no training for personal care aide (PCA) or a medication aide (MA)She did not have a certificate for an Assisted Living AdministratorShe did not have any Administrator training.  Interview with a resident on 07/09/24 at 4:25pm revealed: -The facility did not have an Administrator nowThe Assistant to the Administrator was who she					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.2.1.2.1.1.1	5. GGT120.TGT.	.52.11.1.07.11.01.11.01.15.1.1	A. BUILDING: _		00 22.125
HAL073019		B. WING		R-C <b>07/10/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
DOVDOD	A COLOTED LIVING OR	5660 DUI	RHAM ROAD		
ROXBORG	O ASSISTED LIVING OP	ROXBOR	O, NC 27574		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 182	Continued From page	e 6	D 182		
	went to if she needed	l anything.			
	4:50 pm revealed: -The facility did not hat hat hat hat hat hat hat hat hat ha	Administrator was in charge.  resident on 07/09/24 at resident thought the nistrator was the new  resident on 07/09/24 at resident on was in charge.  With a resident's family at 6:41pm revealed:  Illity every day to feed her retimes she was at the facility real exaministrator/Regional is once.  The Administrator could not and only did paperwork.			
	-The Assistant to the Administrator had previously been the transportation and front desk receptionist and seemed overwhelmed with her				
		new position.  Interview with a dietary staff on 07/09/24 at 4:03pm revealed:			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C
		HAL073019	B. WING		07/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
POYROD	O ASSISTED LIVING OPO	5660 DUR	HAM ROAD		
ROXBOR			O, NC 27574		
(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 APPROPOLICIENCY)	D BE COMPLETE
D 182	Continued From page	e 7	D 182		
	and staff in the facility -She saw the Adminis Operations in the faci she was until a week -She had only seen h -Staff did not know th -She went to the Assi with concerns in the f  Interview with a PCA revealed: -She had only seen th Director of Operations she was only at the fa hour and a half each -The first time she sa agoThe Administrator/Re Operations told her a only concerned about was also the Administ -When she needed so	strator/Regional Director of lity and did not know who later. er twice since May 2024. e chain of command. stant to the Administrator acility.  on 07/09/24 at 4:11am  ne Administrator/Regional is at the facility twice, and acility for thirty minutes to an time. wher was about two weeks egional Director of a few other staff she was it the other facility where she			
	Interview with the RCC on 07/09/24 at 2:00pm revealed: -The Administrator/Regional Director of				
	Operations was at the facility two days a week for about two hours each timeShe was here today, 07/09/24, for about two hours.				

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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.		l BC
		HAL073019	B. WING		R-C <b>07/10/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ROXBORO	O ASSISTED LIVING OPC	5660 DURF	IAM ROAD		
ROXBORG			, NC 27574		
(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 182	Continued From page	: 8	D 182		
	come to the front desk by announcing it on the intercom system and one of the staff informed her she had already left the facility.  Interview with the Assistant to the Administrator on 07/08/24 at 4:17pm revealed:				
	Administrator's position	,			
	Administrator/Regional Director of Operations when the previous Administrator left the position in the middle of May 2024.  -She had previously been responsible for transporting residents to their appointments and monitoring the front desk.				
	-She had not taken th certification exam.				
	because she had too being the Assistant to -She had not had any	aking the certification exam much to do right now with the Administrator. training for the position; the learn what needed to be			
	because the RCC had to a family illness.	y alone most of the time d recently missed work due			
	-She was in charge when the Administrator/Regional Director of Operations was not in the buildingShe reported to the Administrator/Regional Director of OperationsThe Administrator/Regional Director of				
	Operations would not be at the facility on 07/08/24, because she was at a sister facility.				
	on 07/10/24 at 2:58pr -When she was prom transportation/reception	oted from the onist, she was told by the al Director of Operations her			

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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	
			_		R-C	
		HAL073019	B. WING		07/10/202	4
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROXBORO	D ASSISTED LIVING OPO	5660 DURH	AM ROAD			
ROXBORG			, NC 27574			
(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 COM	X5) IPLETE IATE
D 182	2 Continued From page 9		D 182			
	-She went to a meetir was introduced at the Administrator" so that -The RCC helped her paperworkShe was not familiar regulations for the fact was going to read and -She was out of the fact of 107/09/24, because she their appointmentsThe Administrator/Recoperations did the stanew admissions.	ng at another facility and she meeting as the "Assistant was the title she was using. with some of the with the rules and cility; she had a book she delearn them. acility in the morning on the was taking residents to beginnal Director of aff time sheets and handled				
	of Operations on 07/1 -She was the Regional the AdministratorShe was at the facility Thursdays; her hours she usually was at the 4:00pmShe was also the Admin another cityThe Assistant to the Administrator in Charthe facilityThe Assistant to the Administrator in Charthe facility.	Administrator's combined with the Business consibilities which included ring the FL-2s for physicians'				
	B) had a criminal bac upon hire. [Refer to ta	e 2 of 6 sampled staff (A and kground check completed ng 139 G.S. 10A NCAC 13F ff Qualifications (Unabated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		SURVEY PLETED	
		HAL073019	B. WING		l l	R-C / <b>10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		T ADDRESS, CITY, STA	TE, ZIP CODE	1 0.	10/2024
ROXBOR	O ASSISTED LIVING OPO	CO LLC	OURHAM ROAD			
	CLIMMADY CT		ORO, NC 27574	DDOV/DEDIC DI ANI OF	CORRECTION	
(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 182	Continued From page	: 10	D 182			
	interviews, the facility physician's orders for (#3) related to an order to tag 0276, 10A NCA Care (TYPE B VIOLA 3. Based on observat reviews, the facility fa medications as ordereresidents (#3, #4) incl laxative (#3); and a visleep (#4). [Refer to tagent of the content of th	1 of 5 sampled residents er for leg dressings. [Refer AC 13F .0902 (c)(3-4) Health TION)].  ions, interviews, and record iled to administer ed for 2 of 5 sampled luding a nasal spray, and a tamin and a medication for ag 0358, 10A NCAC 13F				
	facility failed to ensure were completed annu results entered onto the #4).[Refer to tag 0253 Resident Assessment 6. Based on observat reviews, the facility far matching therapeutic guidance for 2 of 2 sar with physicians' order concentrated sweets	ions, interviews, and record iled to ensure there were diet menus for food service impled residents (#1, #3)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '			(X3) DATE SURVEY COMPLETED		
				A. BUILDING: _			0
		HAL07301	9	B. WING		R- 07/1	-C 1 <b>0/2024</b>
NAME OF PROVIDER OR SUPPLIE	₹		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROXBORO ASSISTED LIVIN	OP(	CO LLC	5660 DURH ROXBORO	AM ROAD NC 27574			
PREFIX (EACH DEF	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE	JLD BE	(X5) COMPLETE DATE
reviews, the factiets including reserved as order (#1, #3, #4) for a restricted of (#1, #3) and a resupplement with 10A NCAC 13F Service].  8. Based on obstreviews the factive resident's primate clarification of mincluded on an I [Refer to tag 34 Medication Order The Administrate qualified Administrate qualified Administrate and response management, of the facility's politino Administrate to address resident ensure compliant homes when the This failure was and welfare of the Type B Violation.  The facility proving accordance with this violation.	ervatitive de fonce eside once ervatit fair y care edica consikt once at la consikt operation on the consikt operation of the consikt operation of the consistency of	e 11  ions, interviews alled to ensure the phal supplements of 3 of 3 sampled ents with physiciantrated sweets (Int ordered a nutrells (#4). [Refer to It (#4)]. [Refe	erapeutic s were residents ans' orders RCS) diet itional tag 0310, and Food and record ntact with a ') for were not ts (#4). 02(a) re was a o was I entation of There was ely available and to t care ot available. alth, safety titutes a on in (24/24 for	D 182			

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NAME OF PROVIDER OR SUPPLIER  ROXBORO ASSISTED LIVING OPCO LLC  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  RA. BUILDING:  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  FOR DURHAM ROAD  ROXBORO, NC 27574  D  PROVIDER'S PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  5660 DURHAM ROAD  ROXBORO, NC 27574   OKAJIO PREDICINA  GEACH DEFICIENCY MUST BE PRECEDED BY FILL  REGULATORY OR LSC IDENTIFYING INFORMATION)  D 235  Continued From page 12  D 235  10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Examination And Immunizations  (b) Each resident shall have a medical examination extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident.  (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission.	ANDILANC	or connection	BENTI IOATION NOMBER.	A. BUILDING: _			
ROXBORO ASSISTED LIVING OPCO LLC    CA4   ID   SUMMARY STATEMENT OF DEFICIENCIES   D   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PREFIX TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   D   D   PREFIX TAG   P			HAL073019	B. WING		I	024
ROXBORO ASSISTED LIVING OPCO LLC  (A4) ID PREFIX EACH OFFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 235  Continued From page 12  D 235  10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Examination And Immunizations  (b) Each resident shall have a medical examination extender prior to admission to the facility and annually threather. For the purposes of this Rule, Thysician extender means a licensed physician assistant or licensed nurse practitioner. The medical examination completed by a licensed physician or the facility and annually threather means a licensed physician shall be used by the facility to determine if the facility can meet the needs of the resident.  (c) The medical examination shall be completed no more than 90 days prior to the residents admission to the facility, except in the case of emergency admission.  This Rule is not met as evidenced by: Based on record reviews and interviews, the	NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES   FREGULATION MUST BE PRECEDED BY FULL   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE REGULATION OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   CROSS-REFERENCED TO THE APPROPRIATE	ROXBORO	O ASSISTED LIVING OPO	CO LLC				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  D 235  D 236  Continued From page 12  D 235  D 235  D 235  D 235  D 235  D 235  D 236  D 237  D 237  D 237  D 238  D 239  D 236  D 237  D 237  D 238  D 237  D 237  D 238		T	ROXBORO	), NC 27574			
D 235  10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Exam & Immunizatio  10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician essistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE C	(X5) COMPLETE DATE
Medical Exam & Immunizatio  10A NCAC 13F. 0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident.  (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission.	D 235	Continued From page 12		D 235			
(b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident.  (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission.	D 235	D 235 10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Exam & Immunizatio		D 235			
Based on record reviews and interviews, the		Examination And Imm (b) Each resident shat examination complete physician extender properties facility and annually the facility and annually the facility and annually the facility and prior to admission shat determine if the facility resident. (c) The medical examino more than 90 days admission to the facility resident.	nunizations all have a medical ed by a licensed physician or rior to admission to the hereafter. For the purposes an extender" means a esistant or licensed nurse dical examination completed all be used by the facility to ty can meet the needs of the mination shall be completed s prior to the resident's lity, except in the case of				
were completed annually for 1 of 5 residents sampled (#3) and results of the examination were entered onto the FL-2.  The findings are:  Review of Resident #3's FL-2 dated 04/14/23 revealed diagnoses included atrial fibrillation and		Based on record revie facility failed to ensur- were completed annu- sampled (#3) and res entered onto the FL-2 The findings are:	ews and interviews, the re medical examinations ually for 1 of 5 residents sults of the examination were 2.				

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STATEMEN	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
			B WING		R-C
		HAL073019	B. WING		07/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
ROYBOR	O ASSISTED LIVING OPO	SOLIC 5660 DUF	RHAM ROAD		
КОХВОК	O AGGIOTED LIVING OF	ROXBOR	O, NC 27574		
(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 APPROFIDEFICIENCY)	D BE COMPLETE
D 235	Continued From page	e 13	D 235		
	chronic kidney failure				
	Review of Resident #3's record revealed there was not an FL-2 dated after 04/14/23 available for review.				
	outdated. -The Resident Care 0	evealed: 2s for the residents. y Resident #3's FL-2 was			
	Assistant to the Administrator handled the FL-2s.  Telephone interview with a Registered Nurse from Resident #3's primary care provider's (PCP) office on 07/10/24 a 9:30am revealed:  -The facility was supposed to send over the FL-2 when it was due to be updated and the PCP would complete the FL-2 and send it back to the facility.  -She did not see where an updated FL-2 for Resident #3 was received from the facility.				
	on 07/10/24 at 3:58pr -Resident #3 had an order to the facilityThe RCC was respo FL-2s and getting the -The RCC was out of Resident #3 did not g -The FL-2s were supply annually. Interview with the Adr of Operations on 07/1 -The RCC filled out the recent care plan, phy FL-2 and any order of	nsible for filling out the m to the outside providers. work a lot and the FL-2 for et updated. cosed to be updated ministrator/Regional Director 10/24 at 4:43pm revealed: ne FL-2 based on the most sicians orders, previous			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		HAL073019	B. WING		l l	R-C <b>7/10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	E. ZIP CODE		
		5660 DL	JRHAM ROAD	2,2 332		
ROXBOR	O ASSISTED LIVING OPC	ROXBO	RO, NC 27574			
(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 THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 235	facility after the appoi	ought the FL-2 back to the ntment with the physician. sed to review the FL-2 for the PCP if there was	D 235			
D 253	10A NCAC 13F .0801 (a) An adult care hom	(a) Resident Assessment Resident Assessment te shall assure that an initial tesident is completed within to using the Resident	D 253			
	facility failed to ensure each resident was co admission using the F residents (#4). The findings are:	ews and interviews, the e an initial assessment of mpleted within 72 hours of Resident Register for 1 of 5				
	06/20/24 revealed dia mental status, memor behavioral disturbance of the right lung stage Review of Resident #					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	SI CONNECTION	BENTI IOATION NOMBER.	A. BUILDING: _		OOMI LETED
					R-C
		HAL073019	B. WING		07/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
DOVDOD	A SCIETED LIVING OD	5660 DURI	HAM ROAD		
KUNDUK	O ASSISTED LIVING OPC	ROXBORO	, NC 27574		
(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 253	Continued From page	<del>2</del> 15	D 253		
	Telephone interview with Resident #4's Power of Attorney (POA) on 07/09/24 at 6:41pm revealed she was admitted to the facility on 11/06/23.				
	on 07/08/24 at 4:17pr -She was promoted in Administrator's position Administrator/Regions when the previous Adding the middle of May 2 -She had previously be transporting residents monitoring the front decided the second	nto the Assistant to the on by the all Director of Operations Iministrator left the position 2024. Deen responsible for set to their appointments and esk.  It training for the position; the inator (RCC) was helping			
	her learn what needed to be done.  Interview with the Assistant to the Administrator on 07/10/24 at 3:56pm revealed:  -The previous Administrator was responsible for completing the Resident Registers as part of the admissions packet.  -She did not know who audited the residents' records.				
	of Operations on 07/1 -The Resident Regist during the admission -The RCC was workir record audits includin -She was looking at tl completion of all infor signituresThe Resident Regist was the initial assess they were admitted to	ng on completing resident g the Resident Registers. he Resident Registers for mation including dates and er was important because it ment for the resident when			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL073019	B. WING		R-C <b>07/10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
		5660 DUI	RHAM ROAD		
ROXBOR	D ASSISTED LIVING OPC	CO LLC	O, NC 27574		
(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 253	Continued From page 16		D 253		
	RCC were responsibl Resident Registers. -There were Resident				
D 276	10A NCAC 13F .0902	2(c)(3-4) Health Care	D 276		
	10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.				
	This Rule is not met a FOLLOW UP TO THE	as evidenced by: E TYPE A1 VIOLATION			
	The Type A1 Violation Non-compliance conti				
	THIS IS A TYPE B VI	OLATION			
	The findings are:				
		3's current FL-2 dated agnoses of chronic kidney illation.			
		3's physician's order dated order for "dressing change			

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DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			1			_
			B WING		R-0	
		HAL073019	B. WING		07/10	0/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	NOVIBER OR GOLF EIER					
ROXBOR	ASSISTED LIVING OPC	CO LLC	RHAM ROAD			
		ROXBOR	O, NC 27574			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	MAIE	DAIL
D 276	Continued From page	e 17	D 276			
	. •					
	legs daily and as nee	ded" dated 06/17/24.				
	Observation of Reside	ent #3 on 07/08/24 at				
	4:00pm revealed:					
	_	auze dressing in place to				
	Resident #3's left low	•				
		had a handwritten date of				
	06/17/24.					
	-There was no odor.					
	-A medicaion aide (M.	A) was in the room and				
	removed the gauze d	ressing to Resident #3's left				
	leg at the surveyor's r	request.				
	-Resident #3's left low	ver leg had non-pitting				
	edema.					
	-Resident #3's left low	ver leg had areas of dried,				
	cracked skin and her	left foot had a powder like				
	substance that covere	ed the top of her foot.				
	-There was a sock on	Resident #3's right lower				
	leg.	G				
	Observation of Reside	ent #3 on 07/09/24 at				
	9:45am revealed:					
	-Resident #3 was in h	ner wheelchair in her room.				
	-She had socks on bo					
	-She did not have a d	ressing on either leg.				
		llen from her knee down to				
	her foot.					
		ng to the right lower leg or				
	foot.	5g				
	·					
	Interview with Reside	nt #3 on 07/08/24 at 4:05pm				
	revealed:	2 2 20., 2.1 at 1.00p.11				
		doctor about a month ago				
		ge on her left lower leg.				
	-Her left leg had swell					
		would weep fluid from them.				
	-She was not in any p					
	-No one had changed	I the dressing since she had				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION			
7.0.12 1.27.01	0. 002011011	.52	A. BUILDING:	·		PLETED
		HAL073019	B. WING			R-C <b>7/10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
		5660 D	URHAM ROAD			
ROXBOR	O ASSISTED LIVING OPC	CO LLC	ORO, NC 27574			
(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 DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 276	76 Continued From page 18		D 276			
D 276	Review of Resident # 2024 from 07/01/24 to medication administrate revealed:  -There was not an en Resident #3's legs data. There was no docume changes having been any date.  Telephone interview with facility's contracted 10:30 am revealed the an order for Resident changes to her legs of the l	3's June 2024 and July o 07/08/24 electronic ation record (eMAR)  try for dressing changes to ally and prn. The traction of dressing a completed as ordered on the traction of dressing a completed as ordered on the traction of dressing and pharmacy on 07/09/24 at the pharmacy did not receive #3 to have dressing allily and prn.  On 07/08/24 at 4:10pm  The facility to see her of (PCP).  The turned from an PCP, the paperwork went to bordinator (RCC) or the face any new orders to the exact any new orders to the exact any new orders to the exact any and prn.  Resident #3 had an order to the legs daily and prn.  The der to change dressing to	D 276			
	her PCP on 06/17/24 -The Supervisor shou					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (	OF CORRECTION	IDENTIFICATION N	IUMBER:	A. BUILDING: _		COMPL	
		HAL073019		B. WING		l l	R-C / <b>10/2024</b>
		TIALUT 30 13				1 07	110/2024
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
ROXBOR	O ASSISTED LIVING OP	CO LLC	5660 DURH	, NC 27574			
0.0.15	CHMMADV CT	ATEMENT OF DEFICIENC		1	DROVIDERIS DI ANI OF COI	PRECTION	245)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENC Y MUST BE PRECEDED E LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 276	Continued From page	e 19		D 276			
	new orders to the pha	armacy					
	-Orders for dressing		onto the				
	eMAR.	changes should go	onto tric				
	-If orders needed to b	e clarified, the pha	rmacv				
	would contact the fac	•	•				
	-She had not seen the	-					
	have dressing change	es to her legs daily	and prn.				
	-She had not seen Re	esident #3's legs.					
	Interview with the Ass	sistant to the Admin	iotrotor				
	on 07/10/24 at 3:58pi		istiatoi				
	-Resident #3 had chr		ower				
	legs.		OWO!				
	-When she went to se	ee the PCP, they se	ent a				
	folder with a new orde	•					
	it out if there were ne	w orders.					
	-On return to the facil	ity from the appoint	ment, the				
	MAs should fax any r	•	narmacy				
	so the orders were ac						
	-She did not know wh	-					
	dressing changes to	ner legs daily and p	rn did not				
	get implemented.						
	Interview with the Adı	ministrator/Regiona	l Director				
	of Operations on 07/1	10/24 at 4:30pm rev	ealed:				
	-When a resident wer	• • •					
	their PCP, they were						
	included the resident						
	for the PCP to fill out	if there were any ne	ew				
	orders.	sturned from the					
	-When the resident re		folder				
	appointment, the MA should receive the folder back and implement any new orders.						
	-When Resident #3 re	•	CP's				
	office on 06/17/24, th						
	up to check if there w						
	put them into place.		,				
	-The order to change	dressings on Resid	dent #3's				
	legs should have bee						
	-She was concerned	orders were getting	missed.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI	
			A. BUILDING: _			•
		HAL073019	B. WING		07/1	C <b>0/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROXBORO	O ASSISTED LIVING OPC	CO LLC 5660 DURH				
		ROXBORO	, NC 27574			
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 276	Continued From page	<del>2</del> 20	D 276			
	2:15pm revealed: -He saw Resident #3 -Resident #3 had chrolower legsResident #3 did not I stockings because the He wrote the order to needed to decrease sease some of the pair edemaHe knew he could not to her legs but wanted His intent was for the dressing of gauze or a He was not aware Refer legs wrapped dail in place from the appende/17/24He expected orders to facility staff to notify he neededIncreased swelling collegs to leak fluid whice infection.	o wrap her legs daily and as some of the swelling and an associated with the of the fix Resident #3's swelling do to try to reduce it. The staff to apply a snug face wraps daily. The sident #3 was not having ally and the dressing was still ointment with him on to be followed as written or				
	was implemented for chronic swelling in he legs to be wrapped da	a resident (#3) who had er legs and an order for her aily to decresae swelling in				
	leaking of fluid from h wounds and infection detrimental to the hea	d her at risk for swelling, her legs, and development of . This failure was alth, safety, and welfare of stitutes a Type B Violation.				
	The facility provided a accordance with G.S. this violation.	a plan of protection in . 131D-34 on 07/09/24 for				

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AND DIAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL073019	B. WING		R-C <b>07/10/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
ROXBORG	D ASSISTED LIVING OPC	O LLC	RHAM ROAD		
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	RO, NC 27574	PROVIDER'S PLAN OF CORRECTION	I (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 276	Continued From page	21	D 276		
	CORRECTION DATE VIOLATION SHALL N 2024.	FOR THE TYPE B OT EXCEED AUGUST 24,			
D 296	10A NCAC 13F .0904 Service	(c)(7) Nutrition And Food	D 296		
	(c) Menus in Adult Ca (7) The facility shall h diet menu for any resi	Nutrition And Food Service are Homes: have a matching therapeutic dent's physician-ordered idance of food service staff.			
	reviews, the facility fa matching therapeutic	s, interviews, and record iled to ensure there were diet menus for food service mpled residents (#1, #3) s for a restricted			
	The findings are:				
	revealed: -There was a binder was and the theraper-There was a week at week of 07/07/24 to 0	a glance menu for the 7/13/24. us did not have a restricted			

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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 PLAN (	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
		HAL073019	B. WING		R-C <b>07/10/202</b> 4	4
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
POYRODO	ASSISTED LIVING OPO	5660 DUI	RHAM ROAD			
KONBOK	ASSISTED LIVING OF	ROXBOF	O, NC 27574			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COM	(5) PLETE ATE
D 296	Continued From page	e 22	D 296			
	Continued From page 22  -There was a resident diet list for a controlled carbohydrate diet (CCHO); Resident #1 and Resident #3 were on the list for a CCHO diet.  1. Review of Resident #1's current FL-2 dated 04/17/24 revealed diagnoses included diabetes mellitus type 2.					
	dated 11/18/23 revea -Resident #1 was ord concentrated sweets -The RCS diet was de restricted foods high i	ered a restricted (RCS) diet. efined on the order as in sugar or other and fat; the diet allowed				
	Interview with Resident #1 on 07/10/24 at 1:05pm revealed: -He did not know if he had a physician's order for a specific dietHe was served sugar-free foods and drinks during all meals.					
	from the facility's cont on 07/09/24 at 10:51a					
	on 07/09/24 at 8:15ar	with the Kitchen Manager n.				
		s with the Assistant to the 8/24 at 4:17pm and on				
	Refer to the interview Administrator/Region: 07/10/24 at 4:42pm.	with the al Director of Operations on				
	2. Review of Residen	t #3's current FL-2 dated				

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STATE FORM 6899 HSQK11 If continuation sheet 23 of 58

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		E SURVEY PLETED	
		HAL073019	B. WING		<b>I</b>	R-C <b>7/10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE		
ROXBOR	O ASSISTED LIVING OPO	COLLC	RHAM ROAD			
			RO, NC 27574			
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 296	D 296 Continued From page 23		D 296			
	04/14/23 revealed dia fibrillation and chronic	ngnoses included atrial c kidney disease.				
	dated 11/15/23 revea					
	<ul> <li>-Resident #3 was ord concentrated sweets</li> </ul>					
	-The RCS diet was de	efined on the order as				
	restricted foods high in sugar or other concentrated sweets and fat; the diet allowed					
	extra servings of app					
	revealed: -She was a diabeticShe did not think she	nt #3 on 07/10/24 at 1:15pm was on a special diet. me food the other residents				
		interview with the dietitian tracted food supply company am was unsuccessful.				
	Refer to the interview on 07/09/24 at 8:15ar	with the Kitchen Manager n.				
		s with the Assistant to the 8/24 at 4:17pm and on				
	Refer to the interview Administrator/Region 07/10/24 at 4:42pm.	with the al Director of Operations on				
	at 8:15am revealed: -The only therapeutic were for diabetics and	chen Manager on 07/09/24 diets the facility offered d was a CCHO diet. nts were all served the same				

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STATE FORM 6899 HSQK11 If continuation sheet 24 of 58

A. BUILDING: COMPLETED  HAL073019  NAME OF PROVIDER OR SUPPLIER  A. BUILDING: R-C  O7/10/202	024
HAL073019 B. WING 07/10/202	024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ROXBORO ASSISTED LIVING OPCO LLC 5660 DURHAM ROAD	
ROXBORO, NC 27574	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	(X5) OMPLETE DATE
D 296 Continued From page 24 D 296	
The facility had a new contracted food supply company; the new food supply company provided the therapeutic diet menus.  -The new contracted food supply company provided the therapeutic diet menus.  -The new contracted food supply company provided the facility with the new therapeutic diet menus today, 07/09/24.  -The therapeutic diet menus would not be used until the following week and they did not include the RCS diet.  -The kitchen staff served sugar free beverages and desserts to the residents who where diabeticHe would have to let the Assistant to the Administrator or the Administrator/Regional Director of Operations know there was no RCS diet on the menu.  Interview with the Assistant to the Administrator on 07/08/24 at 4:17pm revealed: -She was promoted into the Assistant to the Administrator/Regional Director of Operations when the previous Administrator left the position in the middle of May 2024She had previously been responsible for transporting residents to their appointments and monitoring the front deskShe had not had any training for the position; the RCC was helping her learn what needed to be done.  Interview with the Assistant to the Administrator on 07/10/24 at 3:56pm revealed she did not have any responsibilities regarding the kitchen and the resident diets.  Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:42pm revealed: -The facility was using a new contract food service company.	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		HAL073019	B. WING			R-C 7/ <b>10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E. ZIP CODE		110/2021
		5660 DL	IRHAM ROAD	,		
ROXBORG	O ASSISTED LIVING OPC	ROXBO	RO, NC 27574			
(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	(X5) COMPLETE DATE
D 296	Continued From page	e 25	D 296			
	the physician ordered dietShe had not reviewe to see if the RCS diet -The Kitchen Manage obtaining the therape correct dietsShe and the Assistar	diet menus should match diets; including the RCS d the therapeutic diet menus was included on the menu.				
D 310	10A NCAC 13F .0904 Service	(e)(4) Nutrition and Food	D 310			
	(e) Therapeutic Diets (4) All therapeutic die supplements and thic served as ordered by This Rule is not met					
	reviews, the facility fa diets including nutritic served as ordered for (#1, #3, #4) for reside for a restricted conce	ns, interviews and record iiled to ensure therapeutic onal supplements were and 3 sampled residents ents with physicians' orders intrated sweets (RCS) diet and ordered a nutritional ls (#4).				
	The findings are:					
		t #1's current FL-2 dated agnoses included diabetes				
	Review of Resident #	1's physician's diet order				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		SURVEY PLETED	
						R-C
		HAL073019	B. WING		07	//10/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
ROXBORO	O ASSISTED LIVING OPO	5660 DU	RHAM ROAD			
ПОХВОТ	JACOIOTED LIVING OF	ROXBOF	RO, NC 27574			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 310	Continued From page	26	D 310			
D 310	dated 11/18/23 revea -Resident #1 was ord concentrated sweets -The RCS diet was de restricted foods high i concentrated sweets extra servings of appl  Observation of the kit revealed: -There was a binder was menus and the theray -There was a week at week of 07/07/24 to 0 -The therapeutic men concentrated sweets guidanceThe regular breakfas meal on 07/09/24 cor eggs, bacon, toast, m -The regular menu for consisted of a pork ch cooked cabbage, bea -There was a residen carbohydrate diet (CO Resident #3 were on  Observation of the br from 8:06am to 8:24a -Resident #1 was ser of oatmeal, a half a co slice of bacon and as	led: ered a restricted (RCS) diet. efined on the order as n sugar or other and fat; the diet allowed ropriate foods.  chen on 07/09/24 at 8:20am  which contained the regular resultic diet menus. a glance menu for the 7/13/24. us did not have a restricted (RCS) diet for staff  It menu for the breakfast sisted of oatmeal, confetti ilk and juice. In the lunch meal on 07/09/24 hop, macaroni and cheese, ns, a roll and fruit cocktail. It diet list for a controlled CHO); Resident #1 and the list for a CCHO diet.	D 310			
	water. -Resident #1 ate 100	% of his meal.				
	11:42am to 12:18pm -Resident #1 was ser	nch meal on 07/09/24 from revealed: ved approximately one cup se, a half cup of sautéed				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
ANDILAN	THE TENTO CONTIGORION		A. BUILDING: _		
		HAL073019	B. WING		R-C <b>07/10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ROYBOR	D ASSISTED LIVING OPO	5660 DUF	RHAM ROAD		
КОХВОК	S AGGIOTED LIVING OF	ROXBOR	O, NC 27574	T	
(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 CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROFICIENCY)	ULD BE COMPLETE
D 310	Continued From page	e 27	D 310		
	cabbage, half a cup of cornbread, a half cup and waterResident #1 ate 1000 Based on observation meals served on 07/0 determined if Resider therapeutic diet due to therapeutic diet menufor staff guidance.	of pinto beans, piece of of fruit cocktail, iced tea % of his meal.  ns of the breakfast and lunch 19/24, it could not be nt #1 was served the correct to the kitchen not having a that included an RCS diet			
	Interview with Resident #1 on 07/10/24 at 1:05pm revealed: -He did not know if he had a physician's order for a specific dietHe was served sugar-free foods and drinks during all meals.				
	Interview with Resident #1's primary care provider on 07/10/24 at 10:17am revealed:  -The previous physician had ordered Resident #1 a RCS diet and she continued the order for the diet because he was diabetic.  -She expected the facility to follow all her orders for Resident #1 including his [therapeutic] diet order.				
	from the facility's cont	interview with the dietitian tracted food supply company am was unsuccessful.			
	at 8:15am revealed: -The only therapeutic were for diabetics and -Basically, the resider menu.	chen Manager on 07/09/24  diets the facility offered d was a CCHO diet. nts were all served the same			

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED
		HAI 072040	B. WING		R-C
		HAL073019	] ]:		07/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		5660 DUR	HAM ROAD		
ROXBOR	D ASSISTED LIVING OP	CO LLC ROXBOR	D, NC 27574		
040.15	QUMMADV QT	ATEMENT OF DEFICIENCIES	<del>,</del>	PROVIDER'S PLAN OF CORRECTION	N 0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	( -/
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 310	Continued From page	28	D 310		
2010	Continued From page	3.20	20.0		
	on 07/08/24 at 4:17pr				
	-She was promoted in	nto the Assistant to the			
	Administrator's position	on by the			
	Administrator/Region	al Director of Operations			
	when the previous Ad	lministrator left the position			
	in the middle of May 2	2024.			
	-She had previously b	peen responsible for			
	transporting residents	s to their appointments and			
	monitoring the front d				
	-She had not taken th	ne Administrator's			
	certification exam.				
	-She did not plan on t	taking the certification exam			
		much to do right now with			
	being the Assistant to				
	3				
	Interview with the Ass	sistant to the Administrator			
	on 07/10/24 at 3:56pr	m revealed she did not have			
	Tell control of the c	egarding the kitchen and			
	resident diets.				
	Interview with the Adr	ministrator/Regional Director			
	of Operations on 07/1	10/24 at 4:42pm revealed:			
	-The facility was using	g a new contract food			
	service company.	9			
		menus had been delivered			
	the day before, 07/09				
	•	diet menus should match			
	·	d diets; including the RCS			
	diet.	, 5			
		ed the therapeutic diet menus			
		was included on the menu.			
		er was responsible for			
		utic diet menu with the			
	correct diets.				
		Administrator and the			
		al Director of Operations			
	•	monitoring the therapeutic			
		ere served as ordered to the			
	residents.	CIC 301 VEU AS OIUTIEU IU IIIE			
	เธอเนซิกเอ.		1		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		5.0
		HAL073019	B. WING		R-C <b>07/10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
ROXBOR	O ASSISTED LIVING OPC	CO LLC	HAM ROAD		
	I		D, NC 27574		T
(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	e 29	D 310		
	2. Review of Resident #3's current FL-2 dated 04/14/23 revealed diagnoses included atrial fibrillation and chronic kidney disease.				
	Review of Resident # dated 11/15/23 reveal -Resident #3 was ord concentrated sweets	ered a restricted			
	-The RCS diet was de restricted foods high i	efined on the order as			
	extra servings of appr	ropriate foods.			
	2024 electronic medic	3's June 2024 and July 1-8, cation adminisration record er stick blood sugar results			
	revealed: -She was a diabeticShe did not think she	e was on a special diet.			
	received.	ne food the other residents			
	Resident #3's primary at 9:30am revealed: -Resident #3 was a di RCS diet.	stered Nurse (RN) from v care provider on 07/10/24 iabetic and was ordered a			
	#3's blood sugar leve				
	revealed: -There was a binder was and the therap	chen on 07/09/24 at 8:20am which contained the regular peutic diet menus. t a glance menu for the			
	week of 07/07/24 to 0	7/13/24. us did not have a restricted			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL073019	B. WING		R-C <b>07/10/2024</b>	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
ROXBORO	D ASSISTED LIVING OPO	5660 DURF				
		ROXBORO	, NC 27574			
(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	<del>2</del> 30	D 310			
	concentrated sweets guidanceThe regular breakfas meal on 07/09/24 con eggs, bacon, toast, means a resident consisted of a pork of cooked cabbage, bear arbohydrate diet (COResident #3 were on Observation of the brown 8:06am to 8:24ar-Resident #3 was serroup of scrambled eggs slice of toast with butter and on the property of the pr	ct menu for the breakfast insisted of oatmeal, confetti illk and juice. In the lunch meal on 07/09/24 mop, macaroni and cheese, ins, a roll and fruit cocktail. It diet list for a controlled CHO); Resident #1 and the list for a CCHO diet.  Leakfast meal on 07/09/24 m revealed: Leakfast meal on 07/0				
	11:42am to 12:18pm of Resident #3 was sent of macaroni and cheer cabbage, half a cup of cornbread, a half cup and waterResident #3 ate 75%  Based on observation meals served on 07/0 determined if Resident therapeutic diet due to	ved approximately one cup ese, a half cup of sautéed if pinto beans, piece of of fruit cocktail, iced tea of her meal.  so of the breakfast and lunch				
	-	interview with the dietitian tracted food supply company am was unsuccessful.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	, ,	SURVEY PLETED
,	5. GGT1267.1611		A. BUILDING: _	A. BUILDING:		
		HAL073019	B. WING			R-C 7/ <b>10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		5660 DUR	HAM ROAD			
ROXBOR	O ASSISTED LIVING OPC	O LLC ROXBORG	O, NC 27574			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 310	Continued From page	: 31	D 310			
	Interview with the Kito at 8:15am revealed: -The only therapeutic were for diabetics and	then Manager on 07/09/24 diets the facility offered				
	on 07/08/24 at 4:17pr -She was promoted in Administrator's position Administrator/Regions when the previous Addin the middle of May 2-She had previously but transporting residents monitoring the front dustransporting the front dustransport	ato the Assistant to the on by the all Director of Operations ministrator left the position 2024.  Director of Operations ministrator left the position 2024.  Director responsible for to their appointments and esk.  Director Administrator's aking the certification exam much to do right now with the Administrator.				
	on 07/10/24 at 3:56pr	istant to the Administrator n revealed she did not have garding the kitchen and				
	of Operations on 07/1 -The facility was using service companyThe therapeutic diet the day before, 07/09 -The new therapeutic the physician ordered dietShe had not reviewe	menus had been delivered /24. diet menus should match diets; including the RCS d the therapeutic diet menus was included on the menu.				

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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 PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING:		COMPLETED
		HAL073019	B. WING		R-C
					07/10/2024
NAME OF P	ROVIDER OR SUPPLIER		T ADDRESS, CITY, STA	TE, ZIP CODE	
ROXBOR	ASSISTED LIVING OPC	CO LLC	DURHAM ROAD		
			ORO, NC 27574		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 310	Continued From page	e 32	D 310		
	correct dietsThe Assistant to the Administrator/Regions were responsible for I	Administrator and the al Director of Operations monitoring the therapeutic ere served as ordered to the			
	3. Review of Resident #4's current FL-2 dated 06/20/24 revealed diagnoses included altered mental status, memory disorder, dementia with behavioral disturbances, and malignant neoplasm of the right lung stage four.				
	Review of Resident #4's physician's order dated 06/18/24 revealed:  -There was an order for one can of [named] nutritional supplement vanilla with ice and a straw as needed (PRN) at breakfast and dinner if she did not eat more than 25% of her meal.  -There was an order for one can of vanilla nutritional supplement with ice and a straw served once daily at lunch time.				
	medication administrate revealed: -There was an entry for can with ice and a strain with the scheduled time. There was no docum supplement was serve. There was an entry for can with ice and a strain dinner if the resident of the mealThere was no document of the resident of the meal.	for a nutritional supplement 1 raw once daily at lunch time			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL073019	B. WING		R-C <b>07/10/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DOVDOD	A COLOTED I MINO OD	5660 DUR	HAM ROAD		
ROXBORG	ASSISTED LIVING OPC	ROXBOR	O, NC 27574		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 310	Continued From page	e 33	D 310		
	Review of Resident # 07/01/24 to 07/08/24 -There was an entry f can with ice and a struith the scheduled tin -There was no docum supplement was serve-There was an entry f can with ice and a struith ice and a st	4's July 2024 eMAR from revealed: for a nutritional supplement 1 aw once daily at lunch time ne indicated PRN. Inentation the nutritional ed as ordered on any dates. for nutritional supplement 1 aw PRN at breakfast and did not eat more that 25% of mentation on the entry for			
	-There was no documentation on the entry for nutritional supplement PRN at breakfast and lunch.  Observation of Resident #4 at the lunch meal on 07/09/24 from 11:42am to12:38pm revealed: -She ate 100% of her dessert and then walked out of the dining roomShe returned to the dining room at 11:46am and sat down again; she took a few bites of her macaroni and cheese and left the dining roomShe returned at 11:47am and took a bite of her corn bread after the personal care aide (PCA) cued her to take a bite; she left the dining room againResident #4 continued to walk around and then return to the dining room; she would take a bite of her food each time she sat downShe ate 100% of her pinto beans, less than ¼ of her cornbread, none of her cabbage and 1/3 of her macaroni and cheeseThe PCA served her a cup of nutritional supplement poured over ice with a straw at 12:38pmResident #4 drank 100% of her nutritional supplement.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE Co			E SURVEY PLETED
		HAL073019	B. WING			R-C <b>7/10/2024</b>
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ROXBOR	O ASSISTED LIVING OP	CO LLC	RHAM ROAD RO, NC 27574			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 310	-There was a case of 8-ounce bottles on the refrigeratorThe case of nutrition and 10 bottles of 24 to 10	nutritional supplements, e floor next to Resident #4's all supplement was opened pottles were remaining. The of nutritional supplement in rator. The bottles of nutritional for administration.  With the pharmacist from the harmacy on 07/09/24 at a ponal supplement was by the order dated 06/18/24, and supplement with lunch are order also dated 6/18/24, and supplement PRN for a finot more than 25% of the are orders to the pharmacy and at the profile onto the eMAR.  With a Registered Nurse 4's primary care provider 3:29pm revealed: of Attorney (POA)	D 310			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	1 1		COMPLETED
			7 20.250		R-C
		HAL073019	B. WING	B. WING	
					07/10/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
ROXBOR	O ASSISTED LIVING OPC	CO LLC	RHAM ROAD		
		ROXBOR	O, NC 27574		
(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 310	Continued From page	35	D 310		
D 310	-Resident #4 had an one bottle of nutritional ice with a straw once -Resident #4 had lost 131.6 pounds on 04/1 06/20/24Resident #4 was walterminal illness.  Interview with Reside revealed: -She did not like the supplements] the staf-She did not know hor gave them to herShe did not know who today, 07/09/24 or lur.  Telephone interview v 07/09/24 at 6:41pm re-Resident #4 paced a her entire meal so she have the nutritional surface for Resident #4 because resident #4 had bee was admitted to the fashe had left a full cassupplement at the face 06/18/24 when the PC-On 06/27/24, she as Administrator for an in Resident #4 at a mea	order dated 06/18/24, for al supplement poured over daily at lunch time. some weight; she weighed 15/24, and 122.22 on king more and had a nt #4 on 07/10/24 at 9:45am shakes [nutritional f gave her. w many times a day staff at she ate for breakfast ach yesterday, 07/08/24. with Resident #4's POA on evealed: nd did not want to sit to eat e wanted the resident to	D 310		
	revealed:	on 07/09/24 at 12:09am nave any physician's orders ement.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL073019	B. WING			R-C <b>7/10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
DOVDOD	0 40010TED   IV/INO OD	5660 DL	IRHAM ROAD			
ROXBOR	O ASSISTED LIVING OP	ROXBO	RO, NC 27574			
(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 ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 310	Continued From pag	e 36	D 310			
	-The nutritional supp Resident #4's refrige -Resident #4 would r meal; she would sit of something and then					
	4:11am revealed: -She had served Ressupplement after lunthe resident did not essent with her who supplement and, she she was not told by the nutritional supplet to her at least one management. Resident #4 usually so she never gave here.	le she drank the nutritional drank 100%. anyone to give Resident #4 ment; she tried to give one				
	revealed: -Resident #4's POA nutritional supplement -Resident #4 refused when she was server Resident #4 down the itShe would give the supplement to serve because she did not the resident but the F-She gave the POA to supplement to put in	to Resident #4 with meals stay in the dining room with				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER		A. BUILDING:		COMP	LETED
		HAL073019		B. WING		I	R-C <b>10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	S	TREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DOVDOD	O ACCIOTED I IVING OD	5	660 DURH	AM ROAD			
KUABUKI	O ASSISTED LIVING OPC	R	ROXBORO	, NC 27574			
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 310	Continued From page	e 37		D 310			
	give it to Resident #4 -She had not served to Resident #4 since the because the POA war #4The nutritional supplies of she did not enter it PCP when the reside  Interview with the Asson 07/10/24 at 3:56pr -Resident #4 could not supplement; the MAs her a nutritional suppliementIf there was an order #4's nutritional supplet the MAs should have	the nutritional supplements POA took it to her room nted to give it to Resident ement was not a medicati t on the eMAR or contact nt refused it. sistant to the Administrato n revealed:	ion the r ng				
	on 07/08/24 at 4:17pr -She was promoted ir Administrator's position Administrator/Regions When the previous Addin the middle of May 2 -She had previously be transporting residents monitoring the front desired.	nto the Assistant to the on by the all Director of Operations Iministrator left the positio 2024. Deen responsible for a to their appointments an	on d				
	on 07/10/24 at 3:56pr any responsibilities re- resident diets.  Interview with the Adn of Operations on 07/1 -She was told by the A	m revealed she did not ha egarding the kitchen and ninistrator/ Regional Direc 10/24 at 4:27pm revealed:	etor				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '			SURVEY PLETED
	1141.072040			<b>I</b>	R-C
	HAL0/3019			07	/10/2024
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
O ASSISTED LIVING OPC	COLLC				
OLIMANA DV. OT			DDO//DEDIO DI AN OF OOI	ODEOTION.	1
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETE DATE
Continued From page	38	D 310			
supplement; PRN and -Resident #4 should h nutritional supplemen	d scheduled. nave been getting the t as ordered; the MAs				
10A NCAC 13F .1002	2(a) Medication Orders	D 344			
(a) An adult care horn the resident's physicial for verification or clarify medications and treat (1) if orders for admission admission or readmission or readmissions are not the same The facility shall ensure.	ne shall ensure contact with an or prescribing practitioner fication of orders for timents: sion or readmission of the d and signed within 24 hours nission to the facility; ear or complete; or on forms are received upon sion and orders on the ne.				
* *					
reviews the facility fai resident's primary car clarification of medica	led to ensure contact with a re provider (PCP) for ation orders that were not				
	Continued From page were two different ore supplement; PRN and Resident #4 should hutritional supplement should have followed  10A NCAC 13F .1002  10A NCAC 13F .1002  10A NCAC 13F .1002  (a) An adult care hon the resident's physicia for verification or clarimedications and treat (1) if orders for admission or readmis resident are not dated of admission or readmis forms are not the sam The facility shall ensure clarification is documer record.  This Rule is not met THIS IS A FOLLOW-LVIOLATION  The Type A2 Violation Non-compliance cont  Based on observation reviews the facility fair resident's primary car clarification of medical included on an FL-2 for the supplementary care clarification of medical included on an FL-2 for the supplementary care clarification of medical included on an FL-2 for the supplementary care clarification of medical included on an FL-2 for the supplementary supplementary care clarification of medical included on an FL-2 for the supplementary supplementary care clarification of medical included on an FL-2 for the supplementary	PROVIDER OR SUPPLIER  STREET A  SOASSISTED LIVING OPCO LLC  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 38  were two different orders for the nutritional supplement; PRN and scheduled.  -Resident #4 should have been getting the nutritional supplement as ordered; the MAs should have followed Resident #4's orders.  10A NCAC 13F .1002(a) Medication Orders  (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.  This Rule is not met as evidenced by: THIS IS A FOLLOW-UP TO THE TYPE A2 VIOLATION  The Type A2 Violation was abated. Non-compliance continues.  Based on observations, interviews, and record reviews the facility failed to ensure contact with a resident's primary care provider (PCP) for clarification of medication orders that were not included on an FL-2 for 1 of 5 residents (#4).	ROVIDER OR SUPPLIER  PASSISTED LIVING OPCO LLC  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 38  were two different orders for the nutritional supplement; PRN and scheduledResident #4 should have been getting the nutritional supplement as ordered; the MAs should have followed Resident #4's orders.  10A NCAC 13F .1002(a) Medication Orders  (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:  (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission and orders on the forms are not the same.  The facility shall ensure that this verification or clarification is documented in the resident's record.  This Rule is not met as evidenced by: THIS IS A FOLLOW-UP TO THE TYPE A2 VIOLATION  The Type A2 Violation was abated. Non-compliance continues.  Based on observations, interviews, and record reviews the facility failed to ensure contact with a resident's primary care provider (PCP) for clarification of medication orders that were not included on an FL-2 for 1 of 5 residents (#4).	ROWIDER OR SUPPLIER  ROWIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  5660 DURHAM ROAD  ROWIDER OR SUPPLIER  SIMMARY STATEMENT OF DESCIENCIES  (RACH DEPICIENCY MUST BE PRECEDED BY PULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 38  Were two different orders for the nutritional supplement; PRN and scheduled.  -Resident #4 should have been getting the nutritional supplement as ordered; the MAs should have followed Resident #4's orders.  10A NCAC 13F .1002(a) Medication Orders  (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:  (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.  The facility shall ensure that this verification or clarification is documented in the resident's record.  This Rule is not met as evidenced by: THIS IS A FOLLOW-UP TO THE TYPE A2 VIOLATION  The Type A2 Violation was abated. Non-compliance continues.  Based on observations, interviews, and record reviews the facility failed to ensure contact with a resident's primary care provider (PCP) for clarification of medication orders that were not included on an FL-2 for 1 of 5 residents (#4).	A BUILDING:

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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 PLAN (	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL073019	B. WING		R-C <b>07/10/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		5660 DUR	HAM ROAD		
ROXBOR	D ASSISTED LIVING OPC	CO LLC	O, NC 27574		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 344	Continued From page	e 39	D 344		
D 344	Review of Resident # 06/20/24 revealed: -Diagnoses included a memory disorder, der disturbances, and ma right lung stage fourThere was a note to orders" in the space of to be documentedThere were no medic FL-2 and there were noted attached to the FL-2.  Telephone interview of facility's contracted ple 4:45pm revealed she order list dated 06/20.  Telephone interview of Attorney (POA) on 07-She did not want the FL-2 to the primary cashe wanted to take the she took Resident # 06/20/24; she took the -The facility staff gave herResident #4's FL-2 with she took it to the PCF receive a list of medication aide (MA) medication list wasShe told them the list take to the appointment of the resident Care Communication would print another list would print another list.	altered mental status, mentia with behavioral alignant neoplasm of the "see attached physician's where the medications were cation orders listed on the no medication orders  with the pharmacist from the harmacy on 07/09/24 at did not have a medication /24 for Resident #4.  with Resident #4's Power of 7/09/24 at 6:41pm revealed: a facility to fax Resident #4's are provider's (PCP's) office; he hard copies there herself. 4 to a PCP appointment on a FL-2 with her. A her the FL-2 to take with exast already filled out when a papointment; she did not cations. The FL-2 to the facility, the pasked her where the st was not given to her to	D 344		
		with a Registered Nurse			

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AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C		· · · ·	E SURVEY PLETED
		A. BUILDING:	A. BUILDING:		
	HAL073019	B. WING		I	R-C <b>7/10/2024</b>
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
	5660 D	URHAM ROAD			
ROXBORO ASSISTED LIVING O	PCO LLC	ORO, NC 27574			
PREFIX (EACH DEFICIENT	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC 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 344 Continued From pa	ge 40	D 344			
(RN) from Resident 3:29pm revealed: -The PCP did not he from the facility for the appointment on Resident #4's POA appointments and because of the PCP's office in for Resident #4 in he revealed: -FL-2s were scannel list of medicationsThe medication list resident's current endication name, controlled the revealed because of the provided was the system that startedAfter the FL-2 and signed by the PCP otherThe system for attained at the facility of the provided signed medication of the provided signed signed medication of the provided signed sign	ave a medication order list Resident #4; only the FL-2 at 06/20/24. A brought her to her brought documents with her. haintained a list of medications her record at the office.  CCC on 07/09/24 at 9:51am  and to the PCP along with the lectronic medication and (eMAR), including the losage, and scheduled time. hanned to the pharmacy after by the resident's PCP. he attached physician's orders' bon list were usually written; it be twas in place when she  the medication list were they were attached to each aching the signed physicians' by the resident's PCP.  The attached physicians' by the medication list were they were attached to each aching the signed physicians' by the providers did not return the list with the FL-2. By ponsible for contacting the let a signed copy of the list.  Took her to an outside PCP.  Resident #4' did not have a				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		HAL073019	B. WING		07/10/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ROXBORO	O ASSISTED LIVING OPC	CO LLC	HAM ROAD		
ROXBOR		ROXBORO	, NC 27574		
(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 344	Continued From page	<del>:</del> 41	D 344		
	so it fell through the c	racks.			
	on 07/08/24 at 4:17pr -She was promoted in Administrator's position Administrator/Regional when the previous Addin the middle of May 2-She had previously be transporting residents monitoring the front dustransporting her doneShe had not had any RCC was helping her doneShe reported to the Administrator on 07/0-There should have but attached to Resident printed from the medial-Resident #4's POA to physician and took the appointmentShe did not know if the returned by the POA to back to the facilityThe RCC was responsaling sure the medial PCP.  Interview with the Adrof Operations on 07/1	ato the Assistant to the on by the all Director of Operations ministrator left the position 2024. Deen responsible for to their appointments and esk. Training for the position; the learn what needed to be administrator/Regional s.  In the Assistant to the 8/24 at 12:29pm revealed: een a medication list #4's FL-2; the list was cations on the eMAR. book her to an outside			
	FL-2 and any order ch -The RCC then faxed	the FL-2 to the physician to			
	sign and the family br	ought the FL-2 back to the			

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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. BUILDING.	<del></del>	D.C.
		HAL073019	B. WING		R-C <b>07/10/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
ROXBORO	D ASSISTED LIVING OPO	CO LLC	RHAM ROAD		
		ROXBOR	O, NC 27574		1
(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 344	Continued From page	<del>:</del> 42	D 344		
	accuracy and contact needed correcting or	y the missing medication			
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: ted prescribing practitioner in the resident's record; and on and the facility's policies			
	This Rule is not met a THIS IS A FOLLOW-UVIOLATION	-			
	The Type A1 Violation Non-compliance conti				
	reviews, the facility fa medications as ordere residents (#3, #4) incl				
	policy dated April 201 -Medication shall be a timely manner and as	administered in a safe and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL073019	B. WING			R-C <b>//10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ROYBOR	O ASSISTED LIVING OP	5660 DU	RHAM ROAD			
KONBOK	O ASSISTED LIVING OF	ROXBOI	RO, NC 27574			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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 pag	e 43	D 358			
	after each medicaito -If a medication is wi time other than the s administering the me	MAR on th appropriate line n given. thheld, refused, or given at a chduled time, the individual edication shall initial and e provided for that drug and				
	The findings are:					
	06/20/24 revealed: -Diagnoses included memory disorder, de disturbances, and mright lung stage fourThere was a note to orders" in the space to be documentedThere were no med	"see attached physician's where the medications were ication orders listed on the no medication orders				
	dated 04/08/24 revea	nt #4's physician orders aled there was an order for a sedative for sleep) 50mg at				
		#4's after visit report from the 0/24 revealed there was an the trazadone.				
	medication administr revealed: -There was an entry bedtime scheduled fi -Trazadone was doc 19 of 22 opportunitie	#4's April 2024 electronic ration record (eMAR)  for trazadone 50mg at rom 7:00pm to 11:00pm.  umented as administered for s from 04/08/24 to 04/30/24.  n 04/12/24, resident asleep.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
744012744	or connection	IDENTIFICATION NO.	A. BUILDING:		JONII EETEB
			B. WING		R-C
		HAL073019	b. WING		07/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ROXBORO	O ASSISTED LIVING OPC	CO LLC	HAM ROAD		
		ROXBORO	, NC 27574		
(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 358	Continued From page	e 44	D 358		
	-There was a note on pharmacy. -There was a note on	04/13/24, awaiting on			
	Review of Resident # revealed:	•			
	bedtime scheduled from	or trazadone 50mg at om 7:00pm to 11:00pm. tation trazadone was f 18 opportunities from			
	05/01/24 to 05/22/24.	tation Resident #4 was out			
	of the facility from 05/				
	-There was a note on	05/09/24, awaiting			
	pharmacyThere was a note on	05/22/24 trazadone			
	ordered.	US/22/24, trazadone			
		ocumented after 05/23/24.			
	-There was document	•			
	date.	ntinued but there was no			
	Review of Resident # revealed there was no at bedtime and no do administration on any	o entry for trazadone 50mg cumentation of			
	Interview with Reside revealed:	nt #4 on 07/10/24 at 9:45am			
		at medications she took or			
	-She did not have trou	uble sleeping at night; she			
	never had trouble slee -She never took anyth	eping at night. ning to help her sleep.			
	Interview with Reside 07/10/24 at 1:07pm re -Resident #4 walked	evealed:			
		go, Resident #4 used to			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL073019	B. WING			R-C <b>7/10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
201/202		5660 DU	IRHAM ROAD			
ROXBOR	O ASSISTED LIVING OP	ROXBO	RO, NC 27574			
(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 ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	walk all night longShe would get up ar room for a while and -Resident #4 would were her either coming -About three weeks of stopped walking at nit.  Telephone interview Attorney (POA) on 05-0ne 05/13/24, she will resident #4 out for a not find the trazadone root find the trazadone was, supplies and in the medication aided the trazadone was, supplies and in the medication aided the trazadone was, supplies and in the medication aided the trazadone was, supplies and in the medication aided the trazadone was, supplies and in the medication aided the trazadone was, supplies and in the medication aided the trazadone was, supplies and in the medication aided the trazadone in the medication aided the trazadone interview facility's contracted phenomenated the trazadone on 05/23/24 but they had a verbal of mental health provided trazadone on 05/23/24	and walk and then return to the then get up and leave again. Wake her up and she would gor going.  For a month ago, Resident #4 ight.  With Resident #4's Power of 7/09/24 at 6:41pm revealed: Went to the facility to take a few days and the staff could be.  For (MA) did not know where the looked in the overstock and the and told be it to give her to take with the Resident #4 had not been the taken because the staff dication.  With the pharmacist from the tharmacy on 07/09/24 at the profile for the order for one 50mg once daily on do never filled the order. The redication is to discontinue the staff discontinue the staff discontinue the staff of the order.	D 358			
	Telephone interview (RN) from Resident # (PCP) on 07/09/24 a -Resident #4's PCP I					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
		HAL073019	B. WING		R-C <b>07/10/2024</b>
			<b>!</b>		1 01/10/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATI	E, ZIP CODE	
ROXBOR	O ASSISTED LIVING OPC	COLLC	RHAM ROAD RO, NC 27574		
(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 358	on 06/20/24 because was not administering	the POA reported the facility g it to Resident #4.	D 358		
	have written the order -Trazadone was a secto help sleepIf the trazadone was	I health (MH) provider must r for the trazadone. dative taken in the evening not administered as ordered ave difficulty sleeping at			
	health provider on 07, -She saw the order for filled from 04/04/24She discontinued Re 05/23/24 after she say administered it and the sleeping betterResident #4 was ord insomnia and it was a agitationA possible outcome of the trazodone as order.	with Resident #4's mental /10/24 at 3:02pm revealed: or trazadone had not been esident #4's trazadone on we the resident had not been he staff reported she was ered the trazadone for a safer alternative for mild ered would be the resident			
	awake all night.  Interview with a MA or revealed she did not a Resident #4's trazado Interview with the Asson 07/10/24 at 3:56pr-She made copies of them to the MA after at to her.  -The MAs were response to the pharmacyThe facility's pharma	recall anything about one order.  sistant to the Administrator on revealed: any orders and handed the PCP or POA gave them onsible for faxing any orders cy entered the orders on the e faxed; the MAs approved			

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 BOILBING.		R-C	
		HAL073019	B. WING		07/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROXBOR	O ASSISTED LIVING OPC	CO LLC	HAM ROAD			
		ROXBORO	, NC 27574			
(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	Continued From page	e 47	D 358			
	-She did not know wh were not ordered; sta	y Resident #4's medications ff had not reported anything cations being out of stock or				
	of Operations on 07/1 -If Resident #4 had ar was on the eMAR the facility or on the medi -The RCC and the Materia Resident #4 facilityShe did not understate medications were not the eMARThere were times the certain medicationsThe RCC or a MA we the medication carts to on the medication carts to on the medication was pharmacy the RCC or delivered medicationIf a medication was repharmacy then the RCC contacting the pharmacy the facility's re Resident #4's medicated administrationIf there was an issue for a resident the facilifrom the pharmacy ar	As were responsible for 's trazadone was in the and why Resident #4's at the facility if they were on e insurance would not cover ere responsible for auditing to ensure medications were t. as delivered from the responsible for a the MA checked the against the eMAR. The cot delivered from the CC was responsible for acy and the PCP.				
	Attempted telephone shift PCA on 07/10/24 unsuccessful.	interview with an evening I at 3:33pm was				
	Attempted telephone	interview with a second MA				

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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 PLAN (	A A A A A A A A A A A A A A A A A A A		A. BUILDING: _		COMPLETED	
	HAL073019		B. WING		R-C <b>07/10/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	01/10/2024	
	10115211 011 001 1 21211		HAM ROAD	, 0001		
ROXBOR	D ASSISTED LIVING OP	CO LLC	O, NC 27574			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
D 358	Continued From page	e 48	D 358			
	on 07/10/24 at 3:35ar	m was unsuccessful.				
	orders dated 12/04/23					
	Review of Resident #4's physician's order dated 06/18/24 revealed an order for Vitamin D3 plus Vitamin K2 50mcg/100mcg once daily.  Review of Resident #4's May 2024 electronic medication administration record (eMAR) revealed:					
	-There was an entry f tablet once daily sche 11:00am.	or Vitamin K2 plus D3 one eduled at 7:00am to				
	was administered 23	tation Vitamin K2 plus D3 of 26 opportunities. tation Resident #4 was out				
		05/30/24 and 05/31/24,				
	which read "ordered".					
	Review of Resident # revealed:	4's June 2024 eMAR				
	tablet once daily sche	for Vitamin K2 plus D3 one eduled at 7:00am to				
	11:00amThere was documen was administered 13	tation Vitamin K2 plus D3				
	-There was documen 06/05/24, 06/07/24 to	tation on 06/01/24, 06/10/24, and 06/14/24,				
	"awaiting pharmacy"There was documen	tation on 06/03/24,				
		6/12/24, 06/13/24, 06/15/24, at the resident refused and				
	stated she already to					

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STATE FORM 6899 HSQK11 If continuation sheet 49 of 58

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL073019	B. WING		l l	R-C <b>7/10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		5660 DU	IRHAM ROAD			
ROXBOR	O ASSISTED LIVING OP	CO LLC ROXBO	RO, NC 27574			
(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 T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	read "new script order -There was documer read "ordered".  Observation of Reside on 07/08/24 at 4:39p -There was one med plus D3 50mcg/100m -Twenty-eight tablets 06/20/24; 10 tablets administration.  Telephone interview facility's contracted p4:45pm revealed: -Resident #4 had an Vitamin D3 50mcg/10 -She had a second of Vitamin D3 50mcg/10 -Con 04/23/24, 30 tab Vitamin D3 were dispron 06/20/24, 28 tab Vitamin D3 somcg/10 -There were no other K2 plus Vitamin D3; was not dispensed in -Vitamin D3 aided in and Vitamin K2 work prevented blood clotted Telephone interview (RN) form Resident #4 was ordered sident #4 w	rdered". Intation on 06/19/24, which ered". Intation on 06/20/24, which  Ident #4's medication on hand m revealed: Ication card with Vitamin K2 ncg. Is were dispensed on of 28 were available for  with the pharmacist from the charmacy on 07/09/24 at  order for Vitamin K2 plus Domcg once daily. Interfer for Vitamin K2 plus Domcg written by Resident ovider (PCP) on 06/20/24. Idets of Vitamin K2 plus Domcg were dispensed. Idets of Vitamin K2 plus Domcg were dispensed. In dispense dates for Vitamin Vitamin K2 plus Domcg were dispensed. In dispense dates for Vitamin D3 In May 2024. Ithe absorption of calcium ed like an aspirin and ting.  with a Registered Nurse #4's PCP on 07/09/24 at  dered the Vitamin D3	D 358			
	06/05/23 showed her	re low; her lab work done on r Vitamin D3 level was 20.3 (nmol/L), (Vitamin D3 levels				

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AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	D PLAN OF CORRECTION IDENTIFICATION NUMBER. A.		A. BUILDING: _	COMPLETED		
		HAL073019	B. WING		R-C <b>07/10/20</b> 2	24
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DOVDOD	A A A A A A A A A A A A A A A A A A A	5660 DURI	HAM ROAD			
ROXBORO ASSISTED LIVING OPCO LLC ROXBORO			), NC 27574			
(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 APPROPE DEFICIENCY)	BE CO	(X5) MPLETE DATE
D 358	Continued From page	e 50	D 358			
D 358	of 50nmol/L are consibelow 30nmol/L are to bones)Resident #4 was due again so she was not nowIf the Vitamin D3 was ordered her Vitamin E. The Vitamin K2 was #4 was having some -If the Vitamin K2 was ordered then she wou. The was no bruising appointment on 06/20 Interview with Reside revealed she did not I took or why she took  Telephone interview was took or why she took	idered adequate, levels to low and may weaken to have her lab work done sure what her levels were as not administered as a levels would remain low. ordered because Resident bruising. It is not administered as all have increased bruising. It is noted at Resident #4's 10/24.  In the order of the Vitamin K2 at another pharmacy; the remacy when ordering where ordering to low low low low low low low low low lo	D 358			
	Interview with a MA o revealed: -Resident #4 ran out	n 07/09/24 at 4:25pm of her Vitamin K2 plus				

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STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION	AND DIAN OF CORRECTION IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	- · · · · · · · · · · · · · · · · · · ·	A. BUILDING: _		JOINI LETED	
	HAL073019	B. WING		R-C <b>07/10/2024</b>	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	5660 DUF	RHAM ROAD			
ROXBORO ASSISTED LIVING OPCO I	ROXBOR	O, NC 27574			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 358 Continued From page 51	1	D 358			
Vitamin D3 about a monta-Resident #4 was out of Vitamin D3 for a couple of she tried to reorder it from was told the resident needshe contacted the pharm days because the medicifacility.  -She contacted Resident POA wanted to get the numberself.  -The resident's POA took the new order for the Vita-Once she got the new or pharmacy.  -She documented on the waiting on the pharmacy.  -She did not call Resider POA wanted to be the or PCP.  -She did not tell the Resident (RCC) because the POA Interview with the Assistation 07/10/24 at 3:56pm rewhy Resident #4's medicinate staff had not reported an medications being out of orders.  Interview with the Adminion of Operations on 07/10/24.  -The RCC should have be Resident #4 did not have Vitamin D3 to administer -The MA or the RCC should	th ago. the Vitamin K2 plus of weeks because when m the pharmacy, she eded a new order. macy after about three eation was not in the  t #4's POA because the new order from the PCP  k about two weeks to get amin K2 plus Vitamin D3. order, she faxed it to the e eMAR the facility was c. ht #4's PCP because the nly one in contact with the ident Care Coordinator was handling it.  ant to the Administrator evealed she did not know cations were not ordered; nything to her about the f stock or needing new  istrator/Regional Director 24 at 4:27pm revealed: been made aware e the Vitamin K2 plus f. buld have contacted the tion order and not waited. sible for getting Resident amin D3.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R-C	
		HAL073019	B. WING		07/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ROXBOR	O ASSISTED LIVING OP	CO LLC	RHAM ROAD			
		ROXBOR	O, NC 27574			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 358	Continued From page 52		D 358			
	the eMAR.	at the facility if they were on				
	the medication carts	ere responsible for auditing to ensure medications were				
	on the medication car -When medication wa					
	pharmacy the RCC o					
	delivered medication -If a medication was i	•				
	pharmacy then the R contacting the pharm	CC was responsible for				
		esponsibility to ensure				
	Resident #4's medica administration.	itions were available for				
		ith the Assistant to the 8/24 at 4:17pm and on				
		h the Administrator/Regional s on 07/10/24 at 4:30pm.				
	•	t #3's FL-2 dated 04/14/23				
	revealed diagnoses of chronic kidney diseas					
	a. Review of Resident #3's FL-2 dated 04/14/23 revealed there was an order for fluticasone (a medication used to treat allergies) 50mcg 2 sprays in each nostril daily.  Review of Resident #3's June 2024 electronic					
	medication administrate revealed:	ation record (eMAR)				
		or fluticasone 50mcg 2				
	-Fluticasone 50mcg v administered from 06	vas documented as				
	-There were no refus	als documented.				
	Review of Resident #	3's July 2024 eMAR from				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (	A.		A. BUILDING:		COMP	COMPLETED	
HAL073019		B. WING			R-C <b>10/2024</b>		
NAME OF P	ROVIDER OR SUPPLIER	STREI	ET ADDRESS, CITY, STA	ATE, ZIP CODE			
DOVDOD	A COLOTED LIVING OD	5660	DURHAM ROAD				
RUXBURG	D ASSISTED LIVING OPC	ROXI	BORO, NC 27574				
(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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From page	e 53	D 358				
	07/01/24 to 07/08/24						
	_	for fluticasone (a medication					
	_	s) 50mcg 2 sprays in each					
	nostril daily.						
	•	2 sprays in each nostril daily					
	to 07/08/24	administered from 07/01/24					
	-There were no refus	als documented					
	-There were no relus	ais documented.					
	Observation of Resid	ent #3's medications on					
	hand on 07/08/24 at						
		e of fluticasone 50mcg spray					
	available to administe						
	-The dispensed date	on the bottle of fluticasone					
	50mcg spray was 05/						
	-The bottle was almos	st full.					
	Tolophono intonvious	with a representative from					
		ed pharmacy on 07/09/24 at					
	10:30am revealed:	or pharmacy on 07/09/24 at					
		order for fluticasone 50mcg					
	2 sprays in both nosti						
		oray was used to treat					
	seasonal allergies.						
	-One bottle of fluticas	sone nasal spray 50mcg was					
	dispensed for Reside						
	_	currently on cycle refill and					
	had to request refills.						
	•	requested more fluticasone					
	nasal spray for Resid						
	would last one month	sone nasal spray 50mcg					
		not have any fluticasone					
		to administer if it was being					
	administered as orde						
	Interview with Reside	ont #3 on 07/10/24 of					
	11:30am:	mt #3 011 07/10/24 at					
		with her medications.					
		e received nasal spray from					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION (X3			
			A. BUILDING:	A. BUILDING:		
		HAL073019	B. WING		<b>I</b>	R-C <b>7/10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
DOVDOD	0 40010TED   11/11/0 0D	5660 D	URHAM ROAD			
ROXBOR	O ASSISTED LIVING OPO	ROXBO	DRO, NC 27574			
(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 (EROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 54	D 358			
	the medication aides	(MAs)				
		d her nose got stuffed up.				
	Telephone interview with Resident #3's primary care provider (PCP) on 07/09/24 at 2:15pm revealed: -He ordered fluticasone nasal spray for Resident #3 for seasonal allergies.					
	-He expected Reside medications as order					
	Interview with a MA on 07/10/24 at 11:00am revealed: -Resident #3 had an order for fluticasone 50mcg nasal spray 2 sprays dailyShe administered the fluticasone 50mcg nasal spray when she workedResident #3 did not refuse her fluticasoneShe could not explain why there was still fluticasone nasal spray on the medication cart from May 2024.  b. Review of Resident #'3s FL-2 dated 04/13/23 revealed there was an order for Miralax (a medication used to treat constipation) 17gm in 4 ounces of liquid daily.					
	of liquid daily.	for Miralax 17gm in 4 ounces ocumented as administered 0/24.				
	07/01/24 to 07/08/24 -There was an entry f of liquid daily.	3's July 2024 eMAR for revealed: for Miralax 17gm in 4 ounces ocumented as administered				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:	A. BUILDING:		
						R-C
		HAL073019	B. WING		07	/10/2024
NAME OF P	ROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, STA	TE, ZIP CODE		
DOVDOD!	O ASSISTED LIVING OPC	5660	DURHAM ROAD			
KONBOK	ASSISTED LIVING OF	ROX	BORO, NC 27574			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 55	D 358			
	from 07/01/24 to 07/0	10/04				
	-There were no refusa					
	- There were no reluse	ais documented.				
		ent #3's medications on				
	hand on 07/08/24 at 1					
		e of Miralax available to				
	-The bottle of Miralax	pensed date of 03/19/24.				
	-THE DOLLIE OF WITAIAX	was aimost iuii.				
	Telephone interview v	vith a representative from				
	•	d pharmacy on 0709/24 at				
	10:30am revealed:					
		order for Miralax 17gm in 4				
	ounces of liquid daily.					
	-Miralax was used to					
	-One bottle of Miralax Resident #3 on 03/19	•				
	***	ot dispensed Miralax for				
	Resident #3 on other					
	-The facility was not o	currently on cycle refill and				
	had to request refills.					
	•	equested more fluticasone				
	nasal spray for Resid					
	-One bottle of Miralax month if administered	would last Resident #3 one				
	monun ii auministereu	i as ordered.				
	Interview with Reside	nt #3 on 07/10/24 at				
	11:30am: -She did not keep up	with her medications				
		she received Miralax from				
	the MAs.	Door of manage nom				
	-She was constipated	I sometimes and would ask				
		ring in exlax for her to take.				
	-Telephone interview	with Resident #1's PCP on				
	07/09/24 at 2:15pm re					
		order for Miralax 17gm daily				
	to prevent constipatio					
		Resident #3 to receive her				
	Miralax as ordered to	prevent episodes of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		HAL073019	B. WING		R-C <b>07/10/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE	
ROYBORG	O ASSISTED LIVING OPO	5660 DUI	RHAM ROAD		
KONBOK	ASSISTED LIVING OF	ROXBOF	RO, NC 27574		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE
D 358	Continued From page	e 56	D 358		
	constipation.				
	Interview with a MA or revealed: -Resident #3 had an ounces of liquid dailyShe administered Mishe workedResident #3 did not respectivelyResident #3 did not respectivelyShe could not explain on the medication care.  Refer to interviews with Administrator on 07/0 07/10/24 at 3:58pm.  Refer to interview with Director of Operations.  Interview with Assistate 07/08/24 at 4:17pm respectivelyShe was promoted in Administrator's position Administrator's position Administrator's position Administrator's position and the middle of May 2-She had previously be transporting residents monitoring the front descriptions and the certification examShe did not plan on the because she had too being the Assistant to she had not had any	refuse her Miralax. In why there was still Miralax of from March.  Ith the Assistant to the 8/24 at 4:17pm and on  In the Administrator/Regional of on 07/10/24 at 4:30pm.  In the Administrator on evealed: Into the Assistant to the on by the pail Director of Operations diministrator left the position 2024. In the English of the interest of the position of the Administrator left the position of the interest of their appointments and the early of the interest of their appointments and the early of the interest of their appointments and the early of the interest of their appointments and the early of the interest of their appointments and the early of the interest of their appointments and the early of the interest of the early of the interest of the early of the ea			
		y alone most of the time; the k due to a family illness. hen the			

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  ROXBORO ASSISTED LIVING OPCO LLC  ROXBORO, NC 27574   (X4) ID PREFIX TAG  PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 57  R-C  07/10/2024  RPROVIDER:  B. WING  B. WING  B. WING  PROVIDER:  PROVIDER:  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DATE DEFICIENCY)  D 358  Continued From page 57  D 358		ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVE	Y
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  **TAG**  **TAG**  **TAG**  **ID**  **PREFIX**  **TAG**  **TA	7445 1 2744 01			A. BUILDING:			
ROXBORO ASSISTED LIVING OPCO LLC  ROXBORO, NC 27574   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ROXBORO, NC 27574  ID PROVIDER'S PLAN OF CORRECTION (SACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  DEFICIENCY			HAL073019	B. WING			24
ROXBORO ASSISTED LIVING OPCO LLC  ROXBORO, NC 27574  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  ROXBORO, NC 27574  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  ONLY OF THE PROVIDER'S PLAN OF CORRECTION (CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	NAME OF PRO	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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D 358 Continued From page 57 D 358	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE CO	MPLETE
Administrator/Regional Director of Operations was not in the building.  Interview with the Assistant to the Administrator on 07/10/24 at 3:58pm revealed:  -The MAs were supposed to complete audits of the medications ordered and they received it as ordered.  -She expected the residents to receive their medications as ordered.  Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:30pm revealed:  -The MAs were responsible for completing medication cart audits.  -The Resident Care Coordinator (RCC) was responsible for making sure the medication cart audits were completed but had been out and things were getting missed.  -She expected the residents to receive their medications as ordered.		Administrator/Region was not in the buildin Interview with the Ass on 07/10/24 at 3:58pt - The MAs were support the medication carts a had the medications as ordered She expected the remedications as order Interview with the Adrof Operations on 07/2 - The MAs were responsible for making audits were completed things were getting many - She expected the responsible for making were getting many - She expected the responsible for making were getting many - She expected the responsible for making were getting many - She expected the responsible for making were getting many - She expected the responsible for making were getting many - She expected the responsible for making were getting many - She expected the responsible for making were getting many - She expected the responsible for making were getting many - She expected the responsible for making many - She	sistant to the Administrator m revealed: osed to complete audits of to check that each resident ordered and they received it esidents to receive their red.  ministrator/Regional Director 10/24 at 4:30pm revealed: onsible for completing is. Coordinator (RCC) was no g sure the medication cart ed but had been out and nissed. esidents to receive their	D 358			

Division of Health Service Regulation

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