STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 06/10/25 - 06/13/25 with an exit conference via telephone on 06/13/25. The complaint investigation was initiated by the Hoke County Department of Social Services on 05/30/25.	D 000		
D 077	10A NCAC 13F .0306 (a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a sanitation report in accordance with one of the following: (A) a North Carolina Department of Health and Human Services, Division of Public Health, Environmental Health Section approved sanitation classification at all times in facilities with 12 beds or less, pursuant to the "Rules Governing the Sanitation of Residential Care Facilities", 15A NCAC 18A .1600, which are incorporated by reference including all subsequent amendments and can be accessed electronically free of charge at http://ehs.dph.ncdhhs.gov/rules.htm; and (B) a North Carolina Department of Health and Human Services Division of Public Health, and Environmental Health Section sanitation scores of 85 or above at all times in facilities with 13 beds or more. The "Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes, and Other Institutions", 15A NCAC 18A .1300, can be accessed electronically free of charge at http://ehs.dph.ncdhhs.gov/rules.htm. Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.	D 077	10A NCAC 13F .0306(a)(4) Housekeeping & Furnishing The facility will maintain a sanitation report that is in accordance with the North Carolina Department of Health and Human Services Division of Public Health, and Environmental Health Section sanitation score of 85 or above always in a facility with 13 or more beds. The facility addressed all identified sanitation deficiencies. All residents' rooms, common bathrooms/shower rooms, and other identified areas (e.g., soiled utility room, water fountain, ice cooler) were thoroughly cleaned and sanitized, and ongoing. All bathing equipment was immediately deep cleaned and disinfected. All areas, needing soap and paper towels were immediately stocked and will be ongoing. All unlabeled chemical bottles were properly labeled. Repairs were initiated for holes in the walls and peeling paint in the affected areas. All housekeeping staff and relevant direct care staff (PCAs) will undergo mandatory retraining on proper cleaning protocols, sanitation standards, chemical handling and labeling, and the importance of maintaining a high sanitation standard. This training will emphasize the specific deficiencies identified. The Housekeeping Supervisor will implement, daily rounds to inspect all common areas, resident rooms, and utility rooms to ensure cleanliness and adherence to sanitation standards. The Housekeeping Supervisor will conduct weekly audits of all areas to ensure compliance. A preventative maintenance schedule will be established to inspect and address issues such as the holes in the walls, peeling paint, and water leaks to prevent sanitation breaches, weekly by maintenance director/ designee. Feedback from residents regarding cleanliness will be actively solicited and documented through resident council meetings and satisfaction surveys. The facility contacted the Environmental Health Inspector to request a re-inspection for the facility. They are waiting on a return call with a scheduled date. Corrected date – 7/23/25	

Reviewed and Acknowledged - WW 08/06/25

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D 077	Continued From page 1	D 077		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to maintain an approved sanitation classification from the North Carolina Division of Environmental Health.

The findings are:

Review of the facility's current NC Division of Environmental Health inspection report dated 06/09/25 revealed:
-There were 19 total deductions with a grade of 81.
-There was cleaning needed in residents' rooms.
-There were holes in walls in some bathrooms, and peeling paint.
-There was no soap or paper towels in the soiled utility room.
-There were unlabeled chemical bottles.
-There was bathing equipment used by multiple residents that had black algae and black mold.
-There were several rooms that did not meet the county's water temperature regulation of 105 degrees Fahrenheit.
-There was pink algae in a water fountain.
-There was a dirty ice cooler being used to serve beverages to the residents.

Review of the facility's housekeeping tasks (not dated) on 06/11/25 revealed:
-All housekeeping duties were performed by a housekeeper.
-Clean shower rooms on each hall.
-Clean each residents' room and bathroom.

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D 077	Continued From page 2 Observation of the common bathroom/shower room on Townsend Hall on 06/10/25 at 10:45am revealed: -There was a strong urine odor in the bathroom. -There was a white shower chair beside the trashcan with a pack of adult wipes and an empty plastic bag on the seat. -There was an opened pack of unused adult incontinence briefs on the floor near the white shower chair and trashcan. -There were brown stains in the grout of the tile floor near and around the base of the toilet. -There was a wet brown paper towel on the floor near the toilet. -There was a small hole in the wall and missing paint above the hand soap dispenser near the sink. -There were black stains scattered on the floor near the toilet and sink. -The trashcan near the toilet was filled to the top with soiled adult incontinence briefs and there was a rubber glove hanging over the side of the trashcan. -There was a washcloth with beige and brown stains lying on top of a dingy white towel on the edge of the end of the bathtub. -There was a pack of adult wipes with the lid open beside the stained washcloth on the edge of the end of the bathtub. -There was dirt and debris scattered in the bathtub. -There was an empty cellophane wrapper, a clear plastic deodorant lid, a black round lid, and a clear plastic razor head cover in the bathtub. -There was a light brown stain in the bathtub near the end of the tub. -There was a white, black, and green plastic scrub brush with a handle lying across the drain of the bathtub. -There was a white towel with brown stains lying	D 077		

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D 077	Continued From page 3 on the floor beside the bathtub. -The tile floor between the bathtub and the showers was wet and had black dirt and stains all over it. -There was a gray shower chair turned over on the floor beside the bathtub with all 4 legs sticking up in the air. -There was a wet, stained washcloth lying on the floor near the second shower stall. -There were two white plastic shower curtains hanging near the bathtub and shower stalls with yellow and brown stains. -There was a broom and a mop propped up against the wall between the bathtub and the second shower stall. -The handheld shower head was lying on the floor of the second shower stall, which had dirt and debris and brownish stains on the floor. -There was a wet, white paper towel with brown stains on another shelf in the second shower stall. -The seat and floor in the first shower stall had dirt and debris. -There were brown and green stains on the hard plastic strip on the corner wall to the right side of the first shower stall. -There was a brown dried stain on the wall between the two shower stalls. Observation of the common bathroom/shower room on Jordan Hall on 06/10/25 at 2:45pm revealed: -There were two brooms and 3 mops propped in the corner to the right upon entrance to the bathroom, near a white shower chair. -The floor had scattered dirt and debris throughout the bathroom. -There was scattered dirt and debris on the floor of the shower stalls. -There was a second plastic white shower chair	D 077		

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D 077	Continued From page 4 near the shower stalls with a black seat cushion. -The black seat cushion had white stains all over the top of the cushion. -There was a white shower curtain with yellow and brown stains hanging near the shower chair with the black seat cushion. -There was a wet washcloth on the floor of the shower stall with a toilet shower chair. -There were rust colored stains on the shelf in the shower with the toilet shower chair. Interview with a resident on 06/12/25 at 12:15pm revealed: -The common shower room on Townsend Hall was usually not clean. -There were dirty incontinence briefs everywhere in the bathroom. -There was an odor of urine in the bathroom. -There were dirty towels on the floor every time the resident went to use the shower room on Townsend Hall. Interview with the housekeeping supervisor on 06/11/25 at 12:06pm revealed: -There was a housekeeper assigned to each hall in the facility. -The housekeepers were responsible for cleaning the shower rooms, common areas in the facility and the bathrooms. Interview with the Manager/Operations Specialist on 06/12/25 at 10:11am revealed: -The housekeeping staff were responsible for the cleanliness of the facility. -She expected the housekeeping staff to keep the floors clean, dust, take out trash, clean residents' rooms, and clean showers and common areas of the facility. -She was aware the Environmental Health inspection report dated 06/09/25 revealed a score	D 077		

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D 077	Continued From page 5 of 81. -She felt the facility staff needed more training on how to clean properly.	D 077	10A NCAC 13F .0306(a)(5) Housekeeping & Furnishings The facility will ensure that all areas of the facility are uncluttered, clean, maintained orderly and free of all obstructions and hazards.	
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure 2 of 2 sampled common bathrooms / shower rooms used by residents were uncluttered, clean and orderly in the assisted living (AL) side of the facility. The findings are: Review of the facility's housekeeping tasks (not dated) on 06/11/25 revealed: -All housekeeping duties were performed by a housekeeper. -Clean shower rooms on each hall. -Clean each residents' room and bathroom.	D 079	The facility conducted a deep cleaning and decluttering of all the common bathrooms/ shower rooms. All personal care products were properly stored. All cleaning equipment were immediately removed from common bathrooms/shower rooms and stored in designated housekeeping closets. All housekeeping staff and direct care staff (PCAs) will undergo mandatory retraining on their responsibilities for daily cleaning and tidiness of common bathrooms/shower rooms, including removal of all personal items, soiled linens, and trash after each use. All showers or tubs are to be sanitized after each use. The Housekeeping Supervisor/Designee will conduct daily inspections of all common bathrooms/shower rooms for cleanliness and orderliness. The Administrator/Designee will conduct weekly spot checks of all areas for compliance **Correction Date – 7/23/25**	

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D 079	Continued From page 6 Observation of the common bathroom/shower room on Townsend Hall on 06/10/25 at 10:45am revealed: -There was a strong urine odor in the bathroom. -There was a white shower chair beside the trashcan with a pack of adult wipes and an empty plastic bag on the seat. -There was an opened pack of unused adult incontinence briefs on the floor near the white shower chair and trashcan. -There were brown stains in the grout of the tile floor near and around the base of the toilet. -There was a wet brown paper towel on the floor near the toilet. -There was a small hole in the wall and missing paint above the hand soap dispenser near the sink. -There were black stains scattered on the floor near the toilet and sink. -The trashcan near the toilet was filled to the top with soiled adult incontinence briefs and there was a rubber glove hanging over the side of the trashcan. -There was a washcloth with beige and brown stains lying on top of a dingy white towel on the edge of the end of the bathtub. -There was a pack of adult wipes with the lid open beside the stained washcloth on the edge of the end of the bathtub. -There was dirt and debris scattered in the bathtub. -There was an empty cellophane wrapper, a clear plastic deodorant lid, a black round lid, and a clear plastic razor head cover in the bathtub. -There was a light brown stain in the bathtub near the end of the tub. -There was a white, black, and green plastic scrub brush with handle lying across the drain of the bathtub. -There was a white towel with brown stains lying	D 079		

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D 079	Continued From page 7 on the floor beside the bathtub. -The tile floor between the bathtub and the showers was wet and had black dirt and stains all over it. -There was a gallon jug of shampoo and body wash with no lid sitting on the dirty floor near the two shower stalls. -There was a gray shower chair turned over on the floor beside the bathtub with all 4 legs sticking up in the air. -There was a wet stained washcloth lying on the floor near the second shower stall. -There were two white plastic shower curtains hanging near the bathtub and shower stalls with yellow and brown stains. -There was a broom and a mop propped up against the wall between the bathtub and the second shower stall. -The handheld shower head was lying on the floor of the second shower stall, which had dirt and debris and brownish stains on the floor. -There was a gallon jug of shampoo and body wash with no lid sitting on the shelf in the second shower stall. -There was a wet, white paper towel with brown stains on another shelf in the second shower stall. -The seat and floor in the first shower stall had dirt and debris. -There were brown and green stains on the hard plastic strip on the corner wall to the right side of the first shower stall. -There was a brown dried stain on the wall between the two shower stalls. Interview with a resident on 06/12/25 at 12:15pm revealed: -The common shower room on Townsend Hall was not clean. -There were dirty incontinence briefs everywhere	D 079		

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D 079	Continued From page 8	D 079		

in the bathroom.
-There was an odor of urine in the bathroom.
-There were dirty towels on the floor every time the resident went to use the shower room on Townsend Hall.

Second observation of the common bathroom/shower room on Townsend Hall on 06/10/25 at 2:17pm revealed the room had not been cleaned and it was in the same condition as noted on 06/10/25 at 10:45am except the trashcan had been emptied.

Observation of the common bathroom/shower room on Jordan Hall on 06/10/25 at 2:45pm revealed:
-There were two brooms and 3 mops propped in the corner to the right upon entrance to the bathroom, near a white shower chair.
-The white shower chair was covered with items on the seat including: a box of opened rubber gloves, a clothes hanger, a plastic bin that contained personal care products, a towel, and an opened pack of adult incontinence briefs.
-The floor had scattered dirt and debris throughout the bathroom.
-There was scattered dirt and debris on the floor of the shower stalls.
-There was a second plastic white shower chair near the shower stalls with a black seat cushion.
-The black seat cushion had white stains all over the top of the cushion.
-There was a white shower curtain with yellow and brown stains hanging near the shower chair with the black seat cushion.
-There was a wet washcloth on the floor of the shower stall with a toilet shower chair.
-There were rust colored stains on the shelf in the shower with the toilet shower chair.
-There was a gallon jug of shampoo and body

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D 079	Continued From page 9	D 079		

wash with no lid sitting on a second shelf in the shower with the toilet shower chair.

Interview with a housekeeper on 06/10/25 at 2:20pm revealed:
-She usually worked from 7:30am - 2:30pm.
-There were no housekeepers on duty after hours.
-There was usually one housekeeper and the housekeeping supervisor on duty each day.
-She was assigned to clean the office area and the front halls (Townsend Hall and Jordan Hall).
-The laundry staff was supposed to do housekeeping sometimes as well.
-The personal care aides (PCAs) were supposed to get dirty towels and washcloths up.
-She was supposed to clean the common shower rooms before 9:00am.
-She did not remember what time she cleaned the common shower rooms that morning, 06/10/25.
-She was told not to clean the shower stalls because the PCAs were supposed to clean them.
-She could not recall who told her that or when she was told.
-She usually swept, mopped, cleaned the toilets and sinks, and emptied the trashcans in the common shower rooms.
-She had no explanation for the current condition of the common shower rooms on Townsend Hall and Jordan Hall.

Interview with the Administrator on 06/10/25 at 2:57pm revealed:
-She just started working at the facility on 06/02/25.
-There was housekeeping staff working daily but she did not know how often they were supposed to clean the common shower rooms.
-The housekeeping staff should clean the shower

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D 079	Continued From page 10 stalls, floors, toilet, and sink when they cleaned the shower rooms. Interview with the Resident Care Coordinator (RCC) on 06/10/25 at 3:05pm revealed: -The current condition of the common shower room on Townsend Hall was "unacceptable". -The housekeeping staff should keep the shower rooms clean every day. -The PCAs should clean up towels, shower chairs, and the shower area after each use. Interview with the Manager/Operations Specialist on 06/10/25 at 4:10pm revealed: -The common shower rooms on Townsend Hall and Jordan Hall should have been cleaned today, 06/10/25. -There were usually 2 or 3 housekeepers working each day. -When there were only 2 housekeepers working, laundry staff would help clean in the special care unit. -The housekeeping supervisor was not working today, 06/10/25. -The housekeepers were responsible for cleaning resident rooms and common shower rooms. -The housekeepers were supposed to clean the shower rooms "from top to bottom". -They were supposed to clean the shower stalls, floors, toilet, sink, and empty the trashcan. -The PCAs were supposed to clean up behind themselves after each shower they gave. -The PCAs were supposed to pick up the towels and washcloths after each shower. Interview with the Housekeeping Supervisor on 06/11/25 at 12:06pm revealed: -The housekeepers were responsible for cleaning the shower rooms early in the morning. -He expected the housekeepers to remove towels	D 079		

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D 079	Continued From page 11 or anything on the floors before cleaning.	D 079		
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the electrical call bell system in the assisted living side of the facility was maintained in an operating condition. The findings are: Interview with a personal care aide (PCA) on 06/10/25 at 10:11am revealed: -The call bell panel at the nurses' station was broken and would not sound at the nurses' station. -They would get the call bell panel fixed but it would break again. -It had been broken on and off for the last year. -The call bell lights outside of the residents' room would still light up when the call bells were pressed. -The call bell light was solid when a resident pressed the call bell in the bedroom and the light would blink if a resident pulled the call bell cord in their bathroom. -She looked for the call bell lights to know when a	D 105	10A NCAC 13F .0311(a) Other Requirements The facility will maintain all fire safety, electrical, mechanical and plumbing equipment in safe and operating conditions. The facility immediately contacted a repairman to repair and restore full functionality to the call bell system, including the nurses station panel (audible alarm and monitoring screen) and all residents' rooms. For resident room #33 the bathroom pull cord was repaired. For residents #34 the call bell and pull cord was repaired. A quarterly preventative maintenance schedule will be established with a certified vendor to ensure regular checks, repairs, and calibration. All facility staff will receive mandatory training on the proper use of the call bell system and a immediate reporting protocol for any issues with the call bell system. The Supervisor-In-Charge/Designee on each shift will perform and document a daily check of the call bell system at the nurses' station and randomly selected resident rooms to ensure full functionality. Any issues determined will be documented on a maintenance log and turn over to the Maintenance Supervisor to be addressed. The Maintenance Supervisor will ensure an adequate supply of replacement bulbs and minor repair parts for the call bell system are kept on hand. The Maintenance Supervisor will conduct random checks with residents and staff regarding the functionality of the call bell system. The Resident Care Coordinator will review the daily system check log weekly. **Correction Date – 7/7/25**	

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D 105	Continued From page 12	D 105		

resident had pressed the call bell since the call bell panel at the nurses' station was not sounding.
-The call bells had to be turned off at the wall panels in the residents' rooms.

Interview with a resident on 06/10/25 at 10:27am revealed:
-The call bells did not work correctly.
-The call bells would light up but there was no response at times on all shifts.

Observation of resident room #33 on 06/10/25 at 10:48am revealed:
-The call bell light outside the door was lit up.
-No audible alarm was heard.
-There was one resident present in the room.

Interview with a resident who resided in resident room #33 on 06/10/25 at 10:48am revealed:
-The call bell lights were not working.
-The call bell light outside his room stayed on all the time.
-He had not pressed the call bell today, but the call bell light outside his room door had been on all day.
-He was unsure how long the call bells had not been working properly.

Observation of resident room #34 on 06/10/25 at 10:58am revealed:
-The resident was lying in bed asleep.
-There were two call bell cords plugged into a panel on the wall near the end of the resident's bed.
-Both call bell cords were tied together and laying in a recliner near the end of the resident's bed.
-The call bell light outside of the resident's room was not lit up.

Interview with the same PCA on 06/10/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

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D 105	Continued From page 13 10:59am revealed: -The resident in room #34 was blind and needed assistance by staff with most activities of daily living (ADLs). -The call bell in the resident's bedroom was not working but she could not recall how long it had been broken. -The resident would usually yell for help or get in her wheelchair and propel down the hall and ask staff for help. Interview with a second PCA on 06/11/25 at 8:53am revealed: -The lights from the call bell system turned on without residents pressing the button. -The call bell system was not working. -The Maintenance Director was aware the call bell system was not working properly. Interview with the Manager/Operations Specialist on 06/12/25 at 10:22am revealed: -When the call bell light stayed on and came on without anyone pressing the button it meant the bulb needed to be changed. -She was not aware the call bell system was not working. -She expected staff to report to her or the Maintenance Director when there were issues or concerns with the call bells. Observation of resident room #34 on 06/12/25 at 10:30am revealed: -The call bell panel on the wall was tested and two lights lit up on the wall panel. -The pull cord in the resident's bathroom was tested but did not work. -There was no audible alarm from the call bell panel at the nurses' station. -The call bell light outside of the resident's room did not light up.	D 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 105	Continued From page 14 Observation of the facility's call bell system on Townsend Hall and at the nurses' station on 06/12/25 at 10:31am revealed: -There was a call bell light blinking at resident room #34. -There were 2 speakers at the nurses' station that were turned off and the volume was turned down. -The monitoring screen for the call bell system was black. Interview with the Manager/Operations Specialist on 06/12/25 from 10:30am - 10:33am revealed: -The call bell system was not working in November 2024, so they gave everyone small hand bells until the system was fixed. -The system was repaired at that time and should be working. Interview with the resident residing in resident room #34 on 06/12/25 at 10:34am revealed: -The call bell in her room had not been working for 5 or 6 months. -She was blind and needed some assistance by staff. -Staff usually came and checked on her and helped her get dressed. -If she needed help, she would call out for staff and they usually came. Interviews with the Manager/Operations Specialist on 06/12/25 at 10:55am and 11:12am revealed: -She checked the call bell in resident room #33 and the bathroom pull cord was stuck so she pushed it back in place and it was working now. -The call bell light outside of resident room #33 was not lit up since she fixed the pull cord. -She reset the modem for the call bell system, and it seemed to be working except for the call	D 105		

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D 105	Continued From page 15 bells in resident room #34. -She would get the Maintenance Director to check it. Observation of the facility's call bell system on 06/12/25 at 10:31am revealed: -There was a call bell blinking at resident room #34. -There were 2 speakers at the nurses' station that were turned off and the volume was turned down. -The monitoring screen for the call bell system was black. Interview with a personal care aide (PCA) on 06/11/25 at 8:53am revealed: -The lights from the call bell system turned on without residents pressing the button. -The call bell system was not working. -The Maintenance Director was aware the call bell system was not working properly. Interview with the Manager/Operations Specialist on 06/12/25 at 10:22am revealed: -When the call bell light stayed on and came on without anyone pressing the button it meant the bulb needed to be changes. -She was not aware the call bell system was not working. -She expected staff to report to her or the Maintenance Director when their were issues or concerns with the call bells.	D 105		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water	D 113		

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D 113	Continued From page 16 temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 2 of 5 fixtures sampled that were readily accessible and used by residents with water temperatures ranging from 93.7 degrees F to 115.3 degrees F. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed in the assisted living with a capacity of 68 beds. Review of the facility's census reports provided on 06/10/25 revealed the assisted living's in-house census was 42 residents. Observation of the bathroom in residents' room 10 on the Jordan Hall on 06/10/25 at 10:00am revealed the water temperature at the bathroom sink was 97.7 degrees Fahrenheit (F). Observation of the common bathroom shared by all residents on the Jordan Hall on 06/10/25 at 10:15am revealed the water temperature at the bathroom sink was 98.3 degrees F. Second observation of the bathroom in residents'	D 113	10A NCAC 13F .0311(d) Other Requirements The facility will maintain a hot water system of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soiled utility room. The hot water temperature at all fixtures used by the residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. The facility immediately adjusted the water heaters and added mixing valves to correct affected areas. All staff will be educated about the importance of reporting any issues with water temperatures (too hot or too cold) Immediately to the maintenance supervisor. The maintenance supervisor/designee will conduct and document daily water temperature checks at a minimum of two random areas, on each hall, ensuring that temperatures are in range for compliance. The administrator/designee will be monitored weekly to ensure accuracy. Preventative maintenance schedule will be implemented for all hot water heaters to ensure optimal functioning and consistent temperature output. Any deviations from the acceptable temperature range will trigger immediate action and correction by the Maintenance Supervisor. Corrected date – 7/7/25	

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D 113	Continued From page 17	D 113		

room 10 on the Jordan Hall on 06/10/25 at 1:45pm revealed the water temperature at the bathroom sink was 93.3 degrees F.

Second observation of the common bathroom shared by all residents on the Jordan Hall on 06/10/25 at 1:49pm revealed the water temperature at the bathroom sink was 93.7 degrees F.

Interview with the Maintenance Director on 06/10/25 at 10:30am revealed:
-There were 5 hot water heaters in the facility.
-The residents' halls had their own hot water heater.

Second interview with the Maintenance Director on 06/10/25 at 1:54pm revealed:
-He adjusted the water heater on Townsend Hall and not the hall where the water temperatures were low.
-He did not have anyone inform him the water temperatures were low on the Jordan hall.
-He would adjust the water heater if there were low temperatures, but he did not have low water temperatures.

Third interview with the Maintenance Director on 06/12/25 at 3:28pm revealed he adjusted the water heater on the Jordan Hall this morning, 06/12/25.

Interview with the Manager/Operations Specialist on 06/10/25 at 4:05pm revealed:
-She checked water temperatures once per week and had no water temperatures out of range.
-The Maintenance Director checked the water temperatures every day.
-She expected the Maintenance Director to adjust the hot water heater when water temperatures

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D 113	Continued From page 18 were too low.	D 113		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 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 as evidenced by: Based on interviews and record reviews, the facility failed to implement orders from the primary care provider (PCP) for 1 of 5 residents sampled (#5) who had an order for weekly blood pressure and pulse checks. The findings are: Review of Resident #5's current FL-2 dated 03/18/25 revealed: -Diagnoses included hypertension, type 2 diabetes mellitus, chronic obstructive pulmonary disease, hyperlipidemia, glaucoma, major depressive disorder, congestive heart failure, and legal blindness. -There was an order to check blood pressure (BP) and pulse once a week; notify primary care provider (PCP) if systolic blood pressure (SBP) is greater than (>) 200 or less than (<) 90, diastolic blood pressure (DBP) >110 or pulse greater than or equal to (>)140 or <50. Review of Resident #5's April 2025 - June 2025 electronic medication administration records	D 276	10A NCAC 13F .0902(c)(3-4) Health Care The facility will ensure that documentation of the following is in the resident's record; written procedures, treatments or any orders from a physician or other licensed professional and the implementation of these procedures, treatments or orders. The facility immediately ensured Resident # 5's weekly blood pressure and pulse orders were activated in the medication administration record as ordered by the physician. All orders will be documented on the order log, entered on the Medication Administration Record, activated and documented as per ordered by their physician. A protocol was initiated for managing non-drug orders, such as vitals and oxygen therapy. This protocol will define the responsibilities of the Resident Care Coordinator and Medication Aides for timely entry, activation, and verification of all orders. The Resident Care Coordinator will conduct weekly audits of the order log to ensure all orders are accurate, timely entered and activated. The Resident Care Coordinator and all medication aides attended an in-service training, focusing on the process for entering and activating no-drug orders and the importance of consistent and accurate documentation. The Resident Care Coordinator will conduct weekly checks of The residents vital sign orders to verify that all orders are implemented and documented. The Resident Care Coordinator and Administrator will review the status of order entry and the implementation of the orders weekly as well as monitor for any missed vitals and correct. **Correct Date – 6/16/25**	

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D 276	Continued From page 19 (eMARs) revealed there was no entry for the resident's BP or pulse to be checked for either of the eMARs. Review of Resident #5's Vital Signs Log dated 03/01/25 - 06/10/25 revealed: -There were only 2 documented BP checks. -The resident's BP was 127/82 on 03/10/25 and 176/80 on 06/09/25. -The resident's BP was not documented as being checked weekly as ordered. -There were 7 documented pulse checks. -The resident's pulse was: 68 on 03/19/25; 81 on 04/16/25; 82 on 04/30/25; 80 on 05/07/25; 67 on 05/21/25; 70 on 05/28/25; and 77 on 06/04/25. -The resident's pulse was not documented as being checked weekly as ordered. Interview with Resident #5 on 06/12/25 at 12:40pm revealed: -The facility staff usually checked her BP and pulse about once a month. -Her BP and pulse were "always good". Interview with the Resident Care Coordinator (RCC) on 06/12/25 at 2:54pm revealed: -The pharmacy staff usually entered orders into the eMAR system. -She or the MAs had access to approve orders in the eMAR system. -She was not aware there was no entry on the eMARs to check Resident #5's BP and pulse weekly as ordered. -She just found out today, 06/12/25, that the pharmacy did not enter orders for vital signs into the eMAR system. -Either she or the MAs should have entered the order for the weekly BP and pulse into the eMAR system.	D 276		

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D 276	Continued From page 20 Interview with the Manager/Operations Specialist on 06/12/25 at 4:36pm revealed: -The facility's contracted pharmacy usually entered medication orders into the eMAR system but not orders for vital signs (non-drug orders). -The facility was responsible for entering orders for vital signs into the eMAR system. -Resident #5's order for weekly BP and pulse should have been in the eMAR system so the MAs would know to implement the order. Telephone interview with the Quality Assurance Representative at the facility's contracted pharmacy on 06/12/25 at 5:22pm revealed: -The pharmacy usually entered medication orders into the eMAR system. -Unless a vital sign was included as a parameter for a medication order, the pharmacy did not enter orders for vital signs into the eMAR system. -The facility was responsible for entering orders for vital signs into the eMAR system. Telephone interview with Resident #5's PCP on 06/12/25 at 3:42pm revealed: -She liked to have weekly BP and pulse checks for Resident #5 due to the resident being on multiple medications for BP. -She looked for patterns in the resident's BP and pulse to help determine if changes needed to be made to the resident's BP medications.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 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	D 344		

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D 344	Continued From page 21 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: Based on observations, interviews, and record reviews, the facility failed clarify medication orders for 1 of 5 sampled residents (#3) including a topical ointment for fungal infections and a lubricant gel eye drop. The findings are: Review of Resident #3's current FL-2 dated 01/13/25 revealed diagnoses included unspecified dementia, heart failure, hypothyroidism, hyperlipidemia, chronic obstructive pulmonary disease, and age-related osteoporosis. a. Review of Resident #3's hospital emergency room (ER) after visit summary (AVS) dated 02/15/25 revealed: -The resident was seen for a fall and a fungal skin infection. -There were instructions to start Nystatin Ointment apply topically twice a day. (Nystatin Ointment is a topical antifungal used to treat fungal skin infections.) -There was no documentation to indicate where the resident's fungal skin infection was located or where the medication was to be applied. Review of Resident #3's physician's order sheet	D 344	10A NCAC 13F .1002(a) Medication Orders The facility will ensure that all orders for medications and treatments will be verified or clarified for the reasons identified in 1-3 of this rule area. All orders for medications or treatments will be documented on the order log when the facility receives them. A two-person check will follow all orders and treatments, until completion. Any incomplete or unclear orders will be clarified by the prescribing practitioner. The Resident Care Coordinator and Medication Technicians attended In-Service Training by the facility's contracted pharmacy licensed professional on Medication Orders and Medication Administration on 6/16/2025. the On 7/21/2025, the staff named above attended an In-Service training on Medication Administration which included the following: proper medication administration techniques, properly handling unclear orders, responsibility and accountability of medication aides for assuring medications and treatments are administered as ordered and properly documented, necessary steps to take when medication is not available, and the importance of establishing medication systems. Operational Manager and or Designee will review the order log daily, to ensure that all orders are being followed to completion. Any orders found needing verification will be verified immediately by the Resident Care Coordinator/Designee or Supervisor-In-Charge/Designee. Administrator to review order log Monthly for compliance. **Corrected date – 7/21/25**	

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D 344	Continued From page 22 dated 03/18/25 revealed: -There was an order for Nystatin Ointment 100,000u apply topically twice a day. -The order did not specify where the Nystatin Ointment was to be applied. Review of Resident #3's physician's orders and facility progress notes revealed no documentation the Nystatin Ointment order had been clarified. Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Nystatin Ointment 100,000u apply topically twice a day scheduled at 8:00am and 8:00pm. -Nystatin Ointment was documented as administered in May 2025 but there was no documentation to indicate where the medication was applied. Review of Resident #3's June 2025 eMAR dated 06/01/25 - 06/12/25 revealed: -There was an entry for Nystatin Ointment 100,000u apply topically twice a day scheduled at 8:00am and 8:00pm. -Nystatin Ointment was documented as administered in June 2025 but there was no documentation to indicate where the medication was applied. Observation of Resident #3's medications on hand on 06/11/25 at 2:21pm revealed: -There was a 30-gram tube of Nystatin 100,000u Ointment dispensed on 02/17/25 with instructions to apply topically twice a day. -There was a handwritten note with an open date of 03/01/25. Interview with a medication aide (MA) on 06/11/25	D 344		

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D 344	Continued From page 23 at 2:21pm revealed: -She usually applied the Nystatin Ointment under Resident #3's stomach folds because that was where the resident was always itching. -She did not know why the order had not been clarified. Interview with Resident #3 on 06/12/25 at 5:19pm revealed: -Her back itched every day. -The MAs did not put any kind of ointment on her back or any other part of her body. -She denied any current issues with itching under her stomach folds. Review of Resident #3's pharmacy dispensing records for April 2025 - June 2025 revealed one 30-gram tube of Nystatin Ointment was dispensed on 04/08/25 and 05/21/25. Telephone interview with the Manager/Operations Specialist on 06/13/25 at 9:15am revealed: -The MAs, Resident Care Coordinator (RCC), or Special Care Coordinator (SCC) were responsible for clarifying medication orders. -Resident #3's order for Nystatin Ointment should have been clarified with a route of administration. Telephone interview with Resident #3's primary care provider (PCP) on 06/12/25 at 3:42pm revealed: -The facility usually contacted her if they needed clarification of orders from the ER. -She did not recall the facility contacting her to clarify Resident #3's Nystatin Ointment. b. Review of Resident #3's eye provider visit note dated 03/31/25 revealed the assessment noted the resident had vitreous detachment of the left eye, bilateral hypertensive retinopathy, bilateral	D 344		

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OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

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D 344	Continued From page 24 age-related nuclear cataract, and subconjunctival hemorrhage of the right eye. Review of Resident #3's eye provider order dated 03/31/25 revealed: -There was an order for Refresh Celluvisc 1% Gel eye drops, apply by ophthalmic route 4 times per day into both eyes. (Refresh Celluvisc 1% Gel eye drops are used to treat and prevent dry eyes.) -The order did not specify how many drops to apply to each eye. Review of Resident #3's physician's orders and facility progress notes revealed no documentation the Refresh Celluvisc 1% Gel eye drops order had been clarified. Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Refresh Celluvisc 1% Gel eye drops apply into each eye 4 times a day (wait 3 - 5 minutes between different eye drops), clarify number of drops. -Refresh Celluvisc 1% Gel eye drops were documented as administered in May 2025 but there was no documentation to indicate how many gel drops were applied into each eye. Review of Resident #3's June 2025 eMAR dated 06/01/25 - 06/12/25 revealed: -There was an entry for Refresh Celluvisc 1% Gel eye drops apply into each eye 4 times a day (wait 3 - 5 minutes between different eye drops), clarify number of drops. -Refresh Celluvisc 1% Gel eye drops were documented as administered in June 2025 but there was no documentation to indicate how many gel drops were applied into each eye.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

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D 344	Continued From page 25 Observation of Resident #3's medications on hand on 06/11/25 at 2:19pm revealed: -There was a box of Refresh Celluvisc 1% Gel eye drops dispensed on 05/31/25. -There were 7 of 30 single-use vials remaining in the box. -The instructions were to apply into each eye four times a day (wait 3 - 5 minutes between different eye drops) "clarify number of drops". Interview with a medication aide (MA) on 06/11/25 at 2:19pm revealed: -She usually put 1 drop in each eye of the Refresh Celluvisc 1% Gel eye drops for Resident #3. -She had not noticed documentation on the label and the eMAR indicating the number of drops needed to be clarified. Interview with Resident #3 on 06/12/25 at 5:19pm revealed: -She received eye drops in both eyes every day. -She could not recall how many times a day she received the eye drops. -She thought she received 1 drop in each eye. Review of Resident #3's pharmacy dispensing records for April 2025 - June 2025 revealed one box of 30 single use vials of Refresh Celluvisc 1% Gel eye drops were dispensed on 04/15/25, 05/03/25, 05/19/25, and 05/31/25. Telephone interview with the Manager/Operations Specialist on 06/13/25 at 9:15am revealed: -The MAs, Resident Care Coordinator (RCC), or Special Care Coordinator (SCC) were responsible for clarifying medication orders. -Resident #3's order for Refresh Celluvisc 1% Gel eye drops should have been clarified to	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

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D 344	Continued From page 26 determine how many drops should have been administered into each eye.	D 344		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (#8, #9) observed during the medication pass including errors with an inhaler for chronic obstructive pulmonary disease (#8) and a topical gel for pain relief (#9); and for 2 of 5 residents (#3, #5) sampled for record review including errors with medication for hypothyroidism, irritable bowel syndrome, an antipsychotic, antibiotic, and a moisturizing cream for dry skin (#3); and a muscle relaxer, a potassium supplement, a medication for nerve pain, and a controlled substance used for moderate to severe pain (#5). The findings are:	D 358	10A NCAC 13F .1004(a) Medication Administration The facility will ensure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) Orders by the license prescribing practitioner and maintained in the residents record. (2) Facilities policies and procedures. The facility immediately contacted Resident #3's physician to clarify the exact application site for Nystatin Ointment and the specific number of drops for Refresh Celluvisc 1% Gel eye drops. Once clarified, the medication Administration Record and medication labels were updated with the precise instructions. All orders will be documented on an order log and sent to the pharmacy to be entered into the residents MAR. There will be a two-person check of all orders placed on the residents MAR, to ensure review to identify any discrepancies or errors in preparation, administration, or documentation. All discontinued orders will also be placed on the order log and have a two-person check, reassuring that medication is removed from the residents MAR. All medication discontinued will be removed from the cart and processed for return to the pharmacy.	

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	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

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D 358	Continued From page 27 1. The medication error rate was 5% as evidenced by 2 errors out of 34 opportunities during the 7:00am/8:00am medication pass on 06/11/25. a. Review of Resident #8's current FL-2 dated 10/23/24 revealed: -Diagnoses included type 2 diabetes mellitus, hypertension, and intracranial injury. -There was an order for Trelegy Ellipta 100/62.5/25mcg inhaler use 1 puff once a day, rinse mouth after each use. (Trelegy Ellipta is a dry powder inhaler used for chronic obstructive pulmonary disease. According to the manufacturer, initially the dose counter on the inhaler will show the total number of doses. It counts down by one each time the cover is opened and a dose is taken. When fewer than 10 doses remain, the left half of the counter turns red. After the last dose is inhaled, the counter displays "0" and the inhaler is empty. If the cover is opened again after the last dose, the dose counter will become completely red.) Review of Resident #8's physician's order dated 01/29/25 revealed an order for Trelegy Ellipta 100/62.5/25mcg inhale contents of 1 "click" (1 dose) every day, rinse mouth after use. Observation of the 7:00am medication pass on 06/11/25 revealed: -The medication aide (MA) took a Trelegy Ellipta 100/62.5/25mcg inhaler from a foil pouch with Resident #8's name written on it. -There was no prescription label on the pouch or the inhaler. -The dose counter window on the Trelegy Ellipta inhaler was red with no number showing on the counter. -When the MA was asked why the dose counter	D 358	Resident Care Coordinator and Medication Aides attended In-Service on rule area, Medication Administration, on 6/16/2025. On 7/21/2025, the staff named above attended an In-Service training on Medication Administration which included the following: proper medication administration techniques, properly handling unclear orders, responsibility and accountability of medication aides for assuring medications and treatments are administered as ordered and properly documented, necessary steps to take when medication is not available, and the importance of establishing medication systems. . The Resident Care Coordinator and/or Designee will review the order log daily to ensure all orders are correct, clear, and verified if needed and followed to completion. Resident Care Coordinator and/or Designee will run the Exception Report from Q-Mar daily and review for correct documentation to all orders. Resident Care Coordinator/Designee will conduct a weekly cart audit to ensure all medications and orders are in compliance. **Corrected date – 6/18/25**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

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D 358	Continued From page 28 window was red on the inhaler, she did not answer and proceeded with the medication pass. -The MA pulled the lid back on the inhaler and handed it to the resident without giving any instructions to the resident. -The resident inhaled with his mouth around the mouthpiece of the inhaler twice at 7:50am. -The resident did not receive a dose of Trelegy Ellipta due to the inhaler being empty as indicated by the dose counter window being red. -The MA did not instruct or offer for the resident to rinse his mouth after using the inhaler. Review of Resident #8's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Trelegy Ellipta 100/62.5/25mcg inhale contents of 1 "click" (1 dose) every day, rinse mouth after use. -Trelegy Ellipta was scheduled for administration at 7:00am. -Trelegy Ellipta was documented as administered daily from 06/02/25 - 06/11/25. Observation of Resident #8's medications on hand on 06/11/25 at 1:15pm revealed: -There was one Trelegy Ellipta 100/62.5/25mcg inhaler available for use. -The Trelegy Ellipta inhaler was in the manufacturer's foil tray with the resident's name written in black ink on the manufacturer label on the foil tray. -There was no prescription label for the Trelegy Ellipta inhaler. -The dose counter window on the inhaler was red with no numbers. -There was no other Trelegy Ellipta inhaler on hand for the resident. Interview with Resident #8 on 06/11/25 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

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OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

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D 358	Continued From page 29 12:05pm revealed: -He used the Trelegy Ellipta inhaler every morning. -He sometimes rinsed his mouth after using the inhaler. -The inhaler did not always help with his breathing problems. -The inhaler helped a little at times with his breathing. -He denied any current issues with shortness of breath. Interview with the MA on 06/11/25 at 1:14pm revealed: -She was not aware the red dose counter window meant there were no doses remaining in the Trelegy Ellipta inhaler. -She was not sure when the Trelegy Ellipta inhaler was dispensed because she could not locate the plastic bag with the prescription label that the inhaler came in when it was received by the facility. -She ordered a new Trelegy Ellipta inhaler today, 06/11/25, for Resident #8 and it would be delivered tonight. -She thought the dose counter window on the Trelegy inhaler had been red for a couple of days. -She did not recall having training on how to read dose counters on inhalers. -She did not instruct the resident to rinse his mouth after using the inhaler that morning because the resident did not like to drink or swish with water. Review of Resident #8's pharmacy dispensing record revealed one Trelegy Ellipta 11/62.5/25mcg inhaler with 30 doses was dispensed on 03/28/25. Interview with the Resident Care Coordinator	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

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D 358	Continued From page 30 (RCC) on 06/12/25 at 2:39pm revealed: -The MAs were checked off by a registered nurse (RN) prior to administering medications, which included training on use of inhalers. -The MAs were responsible for reordering medications such as inhalers prior to the medication running out. -She started working at the facility in April 2025 and had just started doing medication cart audits weekly. -She was not aware of Resident #8 having any shortness of breath. Interview with the Manager/Operations Specialist on 06/12/25 at 8:59am revealed: -All MAs had been trained on the use of inhalers by a RN. -The MAs should reorder medications when there was a 7-day supply remaining. -If the dose counter window on the Trelegy Ellipta inhaler was red, the MA should have called the pharmacy and got a new inhaler from the back-up pharmacy. -The MA should also notify the primary care provider (PCP). Interview with the Administrator on 06/12/25 at 9:09am revealed: -She just started working at the facility 7 days ago. -She was still getting familiar with the facility's policies and procedures. -The MAs should administer medications as ordered. Telephone interview with Resident #8's PCP on 06/12/25 at 3:42pm revealed: -Resident #8 had chronic obstructive pulmonary disease and was receiving Trelegy Ellipta for daily maintenance.	D 358		

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	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

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D 358	Continued From page 31 -Not receiving the Trelegy Ellipta daily as ordered could cause the resident to have increased sputum production which could cause increased breathing problems. b. Review of Resident #9's current FL-2 dated 10/16/24 revealed: -Diagnoses included type 2 diabetes mellitus, iron deficiency anemia, Vitamin D deficiency, mixed hyperlipidemia, heart failure, chronic kidney disease, and dementia. -There was an order for Diclofenac Sodium 1% gel apply 2 grams topically to left elbow 4 times daily. (Diclofenac Sodium is a topical gel used to treat pain associated with arthritis.) Observation of the 8:00am medication pass on 06/11/25 revealed: -The medication aide (MA) prepared 2 grams of Diclofenac Sodium 1% gel using a measuring dose card. -The MA applied 2 grams of Diclofenac Sodium 1% gel to Resident #9's right elbow at 8:28am while the resident was lying in bed. -Diclofenac Sodium 1% gel was applied to the resident's right elbow instead of his left elbow as ordered. Review of Resident #9's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Diclofenac Sodium 1% gel apply 2 grams topically to left elbow 4 times a day scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Diclofenac Sodium 1% gel was documented as administered to the left elbow from 8:00am on 06/01/25 - 8:00am on 06/11/25. Observation of Resident #9's medications on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

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D 358	Continued From page 32	D 358		

hand on 06/11/25 at 12:59pm revealed:
-There was a tube of Diclofenac Sodium 1% gel dispensed on 05/10/25.
-The instructions were to apply 2 grams topically to left elbow 4 times a day.
-There was a handwritten note on the label indicating the tube was opened on 05/13/25.
-The tube had approximately 25% of the gel remaining.

Interview with Resident #9 on 06/11/25 at 12:50pm revealed:
-The Diclofenac Sodium 1% gel was not applied every day, but he could not say how often it was applied.
-The MAs usually applied the gel to his right elbow, not the left elbow.
-The gel helped with the pain in his right elbow.
-He denied any pain in his left elbow.

Interview with the MA on 06/11/25 at 12:59pm revealed:
-She usually applied Diclofenac Sodium 1% gel to Resident #9's left elbow.
-She made an error that morning, 06/11/25, when she applied it to the resident's right elbow.
-The resident did not usually complain of pain in either elbow.

Interview with the Special Care Coordinator (SCC) on 06/11/25 at 2:55pm revealed:
-The MAs should follow the instructions on the eMAR and the medication label.
-Resident #9's Diclofenac Sodium 1% gel should have been applied to his left elbow as ordered.
-The resident had not complained of pain in either of his elbows.

Interview with the Manager/Operations Specialist on 06/12/25 at 9:18am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 33	D 358		

-The MAs should focus on the medication pass and make sure topical medications were applied to the correct area.
-Resident #9's Diclofenac Sodium 1% gel should have been applied to the left elbow as ordered.

Interview with the Administrator on 06/12/25 at 9:19am revealed the MAs should read the eMARs and medication labels and follow the instructions.

Telephone interview with Resident #9's primary care provider (PCP) on 06/12/25 at 3:42pm revealed:
-Resident #9 usually complained of hurting all over.
-The MAs needed to check and make sure they were administering the Diclofenac Sodium 1% gel to the left elbow as ordered.
-Resident #9 could have breakthrough pain in his left elbow if the pain gel was not administered to the left elbow.

2. Review of Resident #3's current FL-2 dated 01/13/25 revealed diagnoses included unspecified dementia, heart failure, hypothyroidism, hyperlipidemia, chronic obstructive pulmonary disease, and age-related osteoporosis.

a. Review of Resident #3's electronic prescription dated 05/24/25 revealed:
-There was an order for Cephalexin 500mg 1 capsule twice daily for 7 days for urinary tract infection (UTI). (Cephalexin is an antibiotic for infection.)
-The electronic prescription was date-stamped on 05/24/25 at 7:15am.

Review of Resident #3's May 2025 - June 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 34 electronic medication administration records (eMARs) revealed: -There was an entry for Cephalexin 500mg 1 capsule twice a day for 7 days scheduled at 8:00am and 8:00pm. -The first dose of Cephalexin was documented as administered on 05/26/25 at 8:00pm. -There were 11 doses of Cephalexin documented as administered from 05/26/25 (8:00pm) - 05/31/25 (8:00pm). -There was no entry for Cephalexin on the June 2025 eMAR. -There was no documentation to indicate why there was a delay in starting the Cephalexin ordered on 05/24/25 or why only 11 of 14 doses were documented as administered. Observation of Resident #3's medications on hand on 06/11/25 at 2:13pm revealed there was no Cephalexin available for administration. Interview with Resident #3 on 06/12/25 at 5:19pm revealed: -She remembered taking an antibiotic recently for a UTI, but she could not recall when or how many doses she received. -She denied any current symptoms of UTI. Interview with a medication aide (MA) on 06/11/25 at 2:13pm revealed: -She did not know why there was a delay in starting Resident #3's Cephalexin or why only 11 doses were documented. -She did not know if any Cephalexin capsules were left over or returned to the pharmacy. Review of Resident #3's pharmacy dispensing records for April 2025 - June 2025 revealed there were 14 Cephalexin 500mg capsules dispensed on 05/24/25.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

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D 358	Continued From page 35 Telephone interview with the Quality Assurance Representative at the facility's contracted pharmacy on 06/12/25 at 5:21pm revealed: -They received an electronic prescription for Cephalexin for Resident #3 on 05/24/25. -They dispensed 14 Cephalexin 500mg capsules on 05/24/25. -The Cephalexin was delivered that same night on 05/24/25. -There was no Cephalexin returned to the pharmacy. -The pharmacy entered orders into the eMAR system, but the facility had to review and approve the orders in the eMAR system for the order to become active. -The pharmacy entered the order for Cephalexin into the eMAR system on 05/24/25. -The facility did not activate the order until 05/26/25 at 5:00pm. Interview with the Resident Care Coordinator (RCC) on 06/12/25 at 3:27pm revealed: -It should not take 2 days to start an antibiotic. -The primary care provider (PCP) usually sent electronic prescriptions for antibiotics to the pharmacy so the antibiotic should be started as soon as possible. -The MAs should administer the full dose of antibiotics to ensure effectiveness in treating the infection. -Resident #3 had not complained of any current symptoms of UTI. Telephone interview with Resident #3's PCP on 06/12/25 at 3:42pm revealed: -Antibiotics should be started as soon as received and administered at the next dosing time. -She expected the resident to be administered the complete course of antibiotic to help prevent	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 36	D 358		

the infection from recurring.

b. Review of Resident #3's mental health provider (MHP) order dated 05/08/25 revealed an order for Seroquel 25mg 1 tablet 2 times per day for delusions. (Seroquel is an antipsychotic.)

Review of Resident #3's MHP visit note dated 05/30/25 revealed:
-The resident was started on Seroquel on last visit for delusional thoughts.
-The resident was treated for urinary tract infection, but delusions continued.
-The resident reported the same delusional thoughts; she was "decaying inside", "digging the flakes" out of her stomach/umbilical area and her rectum.
-There was an order to discontinue Seroquel 25mg twice a day; increase to Seroquel 50mg twice a day for delusions.

Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Seroquel 25mg 1 tablet twice a day scheduled for 8:00am and 8:00pm.
-The original dated was noted as 05/08/25.
-The first dose of Seroquel 25mg was documented as administered at 8:00am on 05/12/25.
-Seroquel 25mg twice a day was noted to be discontinued on 05/30/25.
-There was no entry for Seroquel 50mg twice a day as ordered on 05/30/25.

Review of Resident #3's June 2025 eMAR revealed:
-There was an entry for Seroquel 25mg 1 tablet twice a day scheduled for 8:00am and 8:00pm.
-Seroquel 25mg was initialed as administered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 37	D 358		

from 8:00am on 06/01/25 - 8:00pm on 06/03/25.
-The entry for Seroquel 25mg twice daily was blacked out and marked as discontinued on 05/30/25.
-There was an entry for Seroquel 50mg 1 tablet twice daily for delusions scheduled at 8:00am and 8:00pm.
-The first documented dose of Seroquel 50mg being administered was on 06/04/25 with no reason for the delay noted.

Review of Resident #3's pharmacy dispensing records for April 2025 - June 2025 revealed:
-There were 30 Seroquel 25mg tablets dispensed on 05/08/25.
-There were 20 Seroquel 50mg tablets dispensed on 05/30/25.
-There were 56 Seroquel 50mg tablets dispensed on 06/02/25.

Observation of Resident #3's medications on hand on 06/11/25 at 2:13pm revealed:
-There was a supply of Seroquel 50mg tablets with a cycle start date of 06/09/25 with instructions to take 1 tablet twice a day for delusions.
-There were 52 of 56 tablets remaining.

Observation of Resident #3 on 06/10/25 at 10:05am revealed:
-The resident was lying in bed resting.
-The resident pulled the bottom of her shirt up and started rubbing her fingernails across and inside her belly button area.

Interviews with Resident #3 on 06/10/25 at 10:05am and 06/12/25 at 5:19pm revealed:
-She did not recall running out of any medications.
-She had "flakes" in her belly button and rectum

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 38	D 358		

that she had to "dig out".
-She did know all the medications she was currently receiving.

Interview with a medication aide (MA) on 06/11/25 at 2:13pm revealed:
-She was not sure why Resident #3 continued to receive Seroquel 25mg after it was increased on 05/30/25 or why there was a delay in starting the Seroquel 50mg tablets.
-She usually administered what came up on the eMAR screen during the medication passes.

Interview with the Resident Care Coordinator (RCC) on 06/12/25 at 3:24pm revealed:
-She was not aware Resident #3's Seroquel had not been administered as ordered.
-The resident was seeing the MHP because the resident had been having delusions.
-Resident #3 should have started receiving Seroquel 50mg when it was ordered.
-She was unsure why there was a delay in starting the dosage change.
-If there were issues with getting medications, the MAs should notify her.

Telephone interview with the Manager at Resident #3's MHP office on 06/13/25 at 10:05am revealed:
-The MHP was unavailable for interview.
-Not receiving the increased dosage of Seroquel as ordered could have potentially caused the resident to continue to have the same delusions which could lead to anxiety for the resident.

c. Review of Resident #3's current FL-2 dated 01/13/25 revealed an order for Levothyroxine 50mcg 1 tablet once daily. (Levothyroxine is used to treat underactive thyroid disease.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 39 Review of Resident #3's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Levothyroxine 50mcg 1 tablet every day scheduled at 7:00pm. -Levothyroxine was documented as not administered on 06/07/25 and 06/08/25 due to medication not on cart. Review of Resident #3's pharmacy dispensing records for April 2025 - June 2025 revealed: -There were 28 Levothyroxine 50mcg tablets dispensed on 04/07/25. -There were 28 Levothyroxine 50mcg tablets dispensed on 05/05/25. -There were 28 Levothyroxine 50mcg tablets dispensed on 06/02/25. Observation of Resident #3's medications on hand on 06/11/25 at 2:13pm revealed: -There was a supply of Levothyroxine 50mcg tablets with a cycle start date of 06/09/25 with instructions to take 1 tablet every day. -There were 26 of 28 tablets remaining. Interview with Resident #3 on 06/12/25 at 5:19pm revealed: -She was not sure of all the medications she received. -She did not recall if she ran out of any medications. Interview with a medication aide (MA) on 06/11/25 at 2:13pm revealed: -She did not recall Resident #3 running out of Levothyroxine. -Most medications were on a cycle fill and came automatically from the pharmacy. -She was not sure if Levothyroxine was a cycle fill medication.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 40 Interview with the Resident Care Coordinator (RCC) on 06/12/25 at 3:24pm revealed: -The MAs were responsible for ordering medications before they ran out. -She was not aware Resident #3 had missed doses of Levothyroxine. -The MAs should notify her if they had any issues with getting medications from the pharmacy. Telephone interview with the Quality Assurance Representative at the facility's contracted pharmacy on 06/12/25 at 5:21pm revealed: -Levothyroxine was a cycle fill medication every 28 days. -They dispensed Levothyroxine 50mcg for a 28-day supply each on start dates of 04/14/25, 05/12/25, and 06/09/25. -She was not sure why the facility ran out; there should have been enough on hand to administer. Telephone interview with Resident #3's primary care provider (PCP) on 06/12/25 at 3:42pm revealed: -Levothyroxine had to be taken daily at the same time to keep the levels steady. -Not getting Levothyroxine as ordered could cause the resident to feel tired or cold. d. Review of Resident #3's current FL-2 dated 01/13/25 revealed an order for Linzess 290mcg 1 capsule once daily. (Linzess is used to treat irritable bowel syndrome.) Review of Resident #3's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Linzess 290mcg 1 capsule every day scheduled at 7:00am. -Linzess was documented as administered daily	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 41 from 06/01/25 - 06/11/25. Observation of Resident #3's medications on hand on 06/11/25 at 2:13pm revealed there was no Linzess available for administration. Interview with a medication aide (MA) on 06/11/25 at 2:13pm revealed: -Resident #3 had been out of Linzess for 3 days. -Linzess was not a cycle fill medication and had to be ordered by the MAs. -She ordered Linzess for Resident #3 on 06/09/25. -The eMAR showed Linzess was filled on 06/11/25. -She did not know why Linzess had not been received by the facility. -The MA had no explanation when asked why Linzess was documented as administered for the last 3 days when it was not available. Interview with Resident #3 on 06/12/25 at 5:19pm revealed: -She was not sure of all the medications she received. -She did not recall if she ran out of any medications. Telephone interview with the Quality Assurance Representative at the facility's contracted pharmacy on 06/12/25 at 5:21pm revealed: -They dispensed 30 Linzess 290mcg capsules on 04/23/25 and 06/12/25 for Resident #3. -Linzess was not a cycle fill medication and would have to be ordered by the facility prior to running out. Interview with the Resident Care Coordinator (RCC) on 06/12/25 at 3:24pm revealed: -The MAs were responsible for ordering	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 42	D 358		

medications before they ran out.
-She was not aware Resident #3 had missed doses of Linzess.
-The MAs should notify her if they had any issues with getting medications from the pharmacy.

Telephone interview with Resident #3's primary care provider (PCP) on 06/12/25 at 3:42pm revealed:
-Linzess should be taken as ordered to help control symptoms of irritable bowel syndrome.
-Missing doses of Linzess could cause the resident to be constipated.

e. Review of Resident #3's current FL-2 dated 01/13/25 revealed an order for Cerave Cream apply a thin layer topically to the trunk for xerosis (abnormally dry skin) one daily. (Cerave Cream is a topical moisturizer used to treat and prevent dry skin.)

Review of Resident #3's May 2025 - June 2025 electronic medication administration records (eMARs) revealed:
-There was an entry for Cerave Cream apply to trunk for xerosis every day scheduled at 7:00am.
-Cerave Cream was documented as administered daily from 05/01/25 - 06/12/25.

Observation of Resident #3's medications on hand on 06/11/25 at 2:13pm revealed:
-There was a one-pound jar of Cerave Cream dispensed on 01/16/25 with instructions to apply to trunk for xerosis every day.
-None of the Cerave Cream in the one-pound jar had been used.

Review of Resident #3's pharmacy dispensing records for April 2025 - June 2025 revealed no documentation of any Cerave Cream being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 43 dispensed. Telephone interview with the Quality Assurance Representative at the facility's contracted pharmacy on 06/12/25 at 5:21pm revealed they dispensed a one-pound jar of Cerave Cream on 01/16/25 for Resident #3. Interview with Resident #3 on 06/12/25 at 5:19pm revealed: -The MAs did not put any cream on her body, not even when she got her showers. -Her skin was dry and itchy. Interview with a medication aide (MA) on 06/11/25 at 2:13pm revealed: -The one-pound jar of Cerave Cream for Resident #3 was the only jar available for the resident. -Resident #3 did not usually refuse any medications. -She had no explanation as to why the Cerave Cream dispensed on 01/16/25 had not been used. Interview with the Resident Care Coordinator (RCC) on 06/12/25 at 3:24pm revealed: -The MAs should administer Resident #3's Cerave Cream daily as ordered. -The MAs should not document the Cerave Cream was administered if it was not administered. Telephone interview with Resident #3's primary care provider (PCP) on 06/12/25 at 3:42pm revealed: -Resident #3 had dry skin. -Cerave Cream should be used daily to treat and prevent dry skin.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 44 3. Review of Resident #5's current FL-2 dated 03/18/25 revealed diagnoses included type 2 diabetes mellitus, chronic obstructive pulmonary disease, hyperlipidemia, glaucoma, major depressive disorder, hypertension, congestive heart failure, and legal blindness. a. Review of Resident #5's current FL-2 dated 03/18/25 revealed: -There was an order for Tizanidine 4mg 1 tablet at bedtime. (Tizanidine is a muscle relaxer used to treat muscle spasms.) -There was an order for Tizanidine 4mg 1 table twice a day as needed (prn) for muscle spasms. Review of Resident #5's physician's order dated 05/29/25 revealed an order for Tizanidine 4mg twice a day. Observation of Resident #5's medications on hand on 06/11/25 at 1:52pm revealed: -There were two bubble cards of Tizanidine 4mg tablets with a cycle start date of 06/09/25 with instructions to take 1 tablet twice a day. -There were 28 of 28 tablets remaining in one bubble card. -There were 20 of 28 tablets remaining in the other bubble card. -The bubble card with 20 tablets remaining had "PRN" handwritten on the top left corner of the card. Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Tizanidine 4mg 1 tablet at bedtime scheduled at 7:00pm. -Tizanidine was documented as administered at 7:00pm from 05/01/25 - 05/28/25. -Tizanidine 4mg at 7:00pm was documented as	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 45	D 358		

discontinued on 05/29/25.
-There was a second entry for Tizanidine 4mg 1 tablet twice a day scheduled at 7:00am and 7:00pm with a start date of 05/29/25.
-There was no Tizanidine 4mg twice a day documented as administered in May 2025 with no reason noted.
-There was an entry for Tizanidine 4mg 1 tablet twice a day prn for muscle spasms.
-The prn Tizanidine was documented as administered on 21 occasions from 05/01/25 - 05/31/25.

Review of Resident #5's June 2025 eMAR dated 06/01/25 - 06/10/25 revealed:
-There was an entry for Tizanidine 4mg 1 tablet twice a day scheduled at 7:00am and 7:00pm.
-There was no Tizanidine 4mg twice a day documented as administered in June 2025 with no reason noted.
-There was an entry for Tizanidine 4mg 1 tablet twice a day prn for muscle spasms.
-The prn Tizanidine was documented as administered on 8 occasions from 06/01/25 - 06/10/25.

Interview with Resident #5 on 06/12/25 at 12:40pm revealed:
-She thought she was supposed to get Tizanidine twice a day, but she usually had to ask for it when she needed it.
-She took Tizanidine for muscle spasms in her back and legs.

Review of Resident #5's pharmacy dispensing records for April 2025 - June 2025 revealed:
-There were 28 Tizanidine 4mg tablets dispensed on 04/08/25.
-There were 30 Tizanidine 4mg tablets dispensed on 04/16/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 46 -There were 30 Tizanidine 4mg tablets dispensed on 05/02/25. -There were 28 Tizanidine 4mg tablets dispensed on 05/10/25. -There were 30 Tizanidine 4mg tablets dispensed on 05/22/25. -There were 22 Tizanidine 4mg tablets dispensed on 05/29/25. -There were 56 Tizanidine 4mg tablets dispensed on 06/05/25. Telephone interview with the Quality Assurance Representative at the facility's contracted pharmacy on 06/12/25 at 5:22pm revealed: -The pharmacy staff entered orders into the eMAR system. -The facility staff had to verify and approve orders prior to the orders being active in the eMAR system. -The pharmacy received and entered the order for Resident #5's Tizanidine 4mg twice a day into the eMAR system on 05/29/25. -The facility approved the order in the eMAR system on 06/11/25. -The order would not have become active on the eMAR until 06/11/25 because of the delay in the facility approving the order. Interview with a medication aide (MA) on 06/12/25 at 12:22pm revealed: -The Resident Care Coordinator (RCC) and MAs were responsible for approving medication orders in the eMAR system. -She was not aware the order change on 05/29/25 for Tizanidine was not active in the eMAR system until it was brought to her attention by the surveyor yesterday, 06/11/25. -She approved the order dated 05/29/25 for Resident #5 in the eMAR system yesterday, 06/11/25.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 47	D 358		

-She did not know why the order had not been approved and activated on 05/29/25.

Interview with the RCC on 06/12/25 at 2:54pm revealed:
-She was not aware Resident #5 was not receiving Tizanidine as ordered.
-She or the MAs had access to approve medication orders in the eMAR system.
-She was new at the facility and still learning the facility's procedures.
-There needed to be better communication between her and the MAs to make sure all medication orders were approved timely.

Telephone interview with Resident #5's primary care provider (PCP) on 06/12/25 at 3:42pm revealed:
-Resident #5's Tizanidine was managed by the pain clinic.
-The resident should be receiving Tizanidine scheduled twice a day to help manage her pain.
-The resident took pain medications to manage chronic pain syndrome, lumbar radiculopathy (pinched nerve), chronic right and left hip pain, and chronic bilateral low back pain with right side sciatica (pain that radiates along the sciatic nerve from the lower back down the buttock and into the leg).

b. Review of Resident #5's current FL-2 dated 03/18/25 revealed an order for Potassium Chloride ER 10mEq 1 tablet daily. (Potassium Chloride is used to treat and prevent low potassium levels.)

Review of Resident #5's lab results revealed:
-On 01/16/25, the resident's potassium level was 4.6 (within reference range of 3.5 - 5.1).
-On 05/04/25, the resident's potassium level was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 48 5.3 (above reference range of 3.5 - 5.1). Review of Resident #5's physician's order dated 05/09/25 revealed an order to decrease Potassium Chloride ER 10mEq to 1 tablet on Mondays, Wednesdays, and Fridays. Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Potassium Chloride ER 10mEq 1 tablet every day scheduled at 7:00am. -Potassium Chloride ER 10mEq was documented as administered daily at 7:00am from 05/01/25 - 05/09/25, then noted to be discontinued on 05/09/25. -There was a second entry for Potassium Chloride ER 10mEq 1 tablet 3 times a week on Monday, Wednesday, and Friday scheduled at 8:00am with a start date of 05/09/25. -No Potassium Chloride was documented as administered from 05/10/25 - 05/25/25 but 6 doses would have been due on Mondays, Wednesdays, and Fridays during that time period. -The next dose of Potassium Chloride documented was on Monday 05/26/25. -The resident was not administered 6 doses of Potassium Chloride in May 2025. Review of Resident #5's June 2025 eMAR dated 06/01/25 - 06/10/25 revealed: -There was an entry for Potassium Chloride ER 10mEq 1 tablet 3 times a week on Monday, Wednesday, and Friday scheduled at 8:00am. -Potassium Chloride was documented as not administered on Monday, 06/09/25 due to the medication not being on the cart, waiting for meds. Observation of Resident #5's medications on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS RETIREMENT CENTER	612 HEALTH DRIVE RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 49	D 358		

hand on 06/11/25 at 1:52pm revealed:
-There was a supply of Potassium Chloride ER 10mEq with a start date of 06/09/25 and instructions to take 1 tablet 3 times a week on Monday, Wednesday, and Friday.
-There were 12 of 12 tablets remaining.

Interview with Resident #5 on 06/12/25 at 12:40pm revealed she thought she took a potassium supplement but she was not sure how often she received it.

Review of Resident #5's pharmacy dispensing records for April 2025 - June 2025 revealed:
-There were 28 Potassium Chloride ER 10mEq tablets dispensed on 04/07/25.
-There were 28 Potassium Chloride ER 10mEq tablets dispensed on 05/05/25.
-There were 12 Potassium Chloride ER 10mEq tablets dispensed on 05/12/25.
-There were 12 Potassium Chloride ER 10mEq tablets dispensed on 06/04/25.

Interview with a medication aide (MA) on 06/12/25 at 12:22pm revealed:
-She did not know why there was a delay in starting the order change for Resident #5's Potassium Chloride in May 2025.
-She was not sure why the resident ran out of Potassium Chloride in June 2025.
-MAs could reorder medications when there was a 7-day supply remaining.

Telephone interview with the Quality Assurance Representative at the facility's contracted pharmacy on 06/12/25 at 5:22pm revealed:
-The pharmacy staff entered orders into the eMAR system.
-The facility staff had to verify and approve orders prior to the orders being active in the eMAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

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D 358	Continued From page 50	D 358		

system.
-The pharmacy received and entered the order for Resident #5's Potassium Chloride ER 10mEq 3 times a week on Monday, Wednesday, and Friday into the eMAR system on 05/09/25.
-The facility approved the order in the eMAR system on 05/25/25.
-The order would not have become active on the eMAR until 05/25/25 because of the delay in the facility approving the order.

Interview with the Resident Care Coordinator (RCC) on 06/12/25 at 2:54pm revealed:
-She was not aware Resident #5 was not receiving Potassium Chloride as ordered.
-The order change for Potassium Chloride may not have been approved in the eMAR system.
-She or the MAs had access to approve medication orders in the eMAR system.
-She was new at the facility and still learning the facility's procedures.
-There needed to be better communication between her and the MAs to make sure all medication orders were approved timely.

c. Review of Resident #5's current FL-2 dated 03/18/25 revealed an order for Oxycodone / Acetaminophen(APAP) 7.5/325mg 1 tablet every 6 hours for pain. (Oxycodone/APAP is a controlled substance used to treat moderate to severe pain.)

Review of Resident #5's primary care provider (PCP) visit note dated 04/29/25 revealed:
-The resident had chronic pain managed by the pain clinic.
-The resident was being treated for chronic bilateral hip pain and lumbar radiculopathy (pinched nerve in the lower back).

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	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

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D 358	Continued From page 51 Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone/APAP 7.5/325mg 1 tablet every 6 hours for chronic pain scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm. -Oxycodone/APAP 7.5/325mg was documented as not administered at 6:00pm on 05/05/25 due to the medication reordered, waiting for medication. Review of Resident #5's June 2025 eMAR dated 06/01/25 - 06/10/25 revealed: -There was an entry for Oxycodone/APAP 7.5/325mg 1 tablet every 6 hours scheduled at 12:00am, 6;00am, 12:00pm, and 6:00pm. -Oxycodone/APAP 7.5/325mg was documented as administered from 8:00am on 06/01/25 - 12:00pm on 06/10/25. Review Resident #5's May 2025 - June 2025 controlled substance (CS) logs revealed: -There was no Oxycodone/APAP documented as administered and declined from the CS log for 05/05/25 at 6:00pm. -There was no Oxycodone/APAP documented as administered and declined from the CS log for 06/07/25 at 6:00pm. -Oxycodone/APAP 7.5/325mg was not administered on 05/05/25 and 06/07/25 at 6:00pm. Review of Resident #5's pharmacy dispensing records for April 2025 - June 2025 revealed: -There were 120 Oxycodone/APAP 7.5/325mg tablets dispensed on 04/05/25. -There were 120 Oxycodone/APAP 7.5/325mg tablets dispensed on 05/05/25. -There were 120 Oxycodone/APAP 7.5/325mg tablets dispensed on 06/04/25.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

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D 358	Continued From page 52 Observation of Resident #5's medications on hand on 06/11/25 at 2:00pm revealed: -There was a supply of Oxycodone/APAP 7.5/325mg tablets dispensed on 05/30/25 with instructions to take 1 tablet every 6 hours. -There were 93 of 120 tablets remaining. Interview with Resident #5 on 06/12/25 at 12:40pm revealed: -The facility sometimes ran out of her Oxycodone/APAP. -She thought they usually got in back in stock later the same day. -Most of the time if they were out of the Oxycodone/APAP, she was still able get Gabapentin (used for nerve pain) so that helped control her pain when she was out of Oxycodone/APAP. Interview with a medication aide (MA) on 06/12/25 at 12:22pm revealed: -The MAs were supposed to order controlled substances when there was a 7-day supply remaining. -If refills were needed for a controlled substance, the Resident Care Coordinator (RCC) usually handled that. -The facility changed pharmacies earlier this year and everyone's controlled substances got messed up and some had to be reordered. -She was not sure why Resident #5 ran out of Oxycodone/APAP. Interview with the RCC on 06/12/25 at 2:54pm revealed: -Resident #5's controlled substances were prescribed by the pain clinic provider. -The pharmacy needed a new prescription every 30 days for controlled substances.	D 358		

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	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

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D 358	Continued From page 53 -If the MAs tried to refill Resident #5's Oxycodone/APAP without a new prescription, it could delay the process. -Resident #5's Oxycodone/APAP prescription was not gotten in time to prevent a delay in getting the medication. -They recently started getting the facility's Transporter to get new prescriptions at appointments to try to prevent a delay. Interview with the Manager/Operations Specialist on 06/12/25 at 4:36pm revealed: -She was not aware Resident #5 had missed doses of Oxycodone/APAP. -The MAs and the RCC were responsible for ordering medications, including controlled substances. -Controlled substances should be ordered when there was a 7-day supply remaining. -If a new prescription was needed, the MAs or the RCC should contact the provider when there was a 7-day supply remaining. Telephone interview with Resident #5's primary care provider (PCP) on 06/12/25 at 3:42pm revealed: -Resident #5's Oxycodone/APAP was managed by the pain clinic. -The resident took pain medications to manage chronic pain syndrome, lumbar radiculopathy (pinched nerve), chronic right and left hip pain, and chronic bilateral low back pain with right side sciatica (pain that radiates along the sciatic nerve from the lower back down the buttock and into the leg). Attempted telephone interview with Resident #5's pain clinic provider on 06/12/25 at 4:25pm was unsuccessful.	D 358		

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	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

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D 358	Continued From page 54 d. Review of Resident #5's current FL-2 dated 03/18/25 revealed an order for Gabapentin 600mg 1 tablet 3 times a day. (Gabapentin is used to treat nerve pain.) Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Gabapentin 600mg 1 tablet 3 times a day scheduled at 7:00am, 1:00pm, and 7:00pm. -Gabapentin was documented as not being administered from 7:00am on 05/19/25 - 7:00am on 05/20/25 due to waiting for meds, should be in tonight. -There were 4 doses of Gabapentin not documented as administered in May 2025. Review Resident #5's May 2025 controlled substance (CS) logs revealed there was no Gabapentin documented as administered and declined from the CS log from 7:00pm on 05/18/25 - 7:00pm on 05/20/25, for a total of 7 missed doses in May 2025. Review of Resident #5's pharmacy dispensing records for April 2025 - June 2025 revealed: -There were 90 Gabapentin 600mg tablets dispensed on 04/19/25. -There were 90 Gabapentin 600mg tablets dispensed on 05/20/25. Observation of Resident #5's medications on hand on 06/11/25 at 2:00pm revealed: -There was a supply of Gabapentin 600mg tablets dispensed on 05/20/25 with instructions to take 1 tablet 3 times a day. -There were 23 of 90 tablets remaining. Interview with Resident #5 on 06/12/25 at	D 358		

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D 358	Continued From page 55 12:40pm revealed: -The facility sometimes ran out of her Gabapentin. -She thought they usually got in back in stock later the same day. -Most of the time if they were out of the Gabapentin, she was still able get Oxycodone/Acetaminophen (a controlled substance for moderate to severe pain) so that helped control her pain when she was out of Gabapentin. Interview with a medication aide (MA) on 06/12/25 at 12:22pm revealed: -The MAs were supposed to order controlled substances when there was a 7-day supply remaining. -If refills were needed for a controlled substance, the Resident Care Coordinator (RCC) usually handled that. -The facility changed pharmacies earlier this year and everyone's controlled substances got messed up and some had to be reordered. -She was not sure why Resident #5 ran out of Gabapentin. Interview with the RCC on 06/12/25 at 2:54pm revealed: -Resident #5's controlled substances were prescribed by the pain clinic provider. -The pharmacy needed a new prescription every 30 days for controlled substances. -If the MAs tried to refill Resident #5's Gabapentin without a new prescription, it could delay the process. -Resident #5's Gabapentin prescription was not gotten in time to prevent a delay in getting the medication. -They recently started getting the facility's Transporter to get new prescriptions at	D 358		

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D 358	Continued From page 56 appointments to try to prevent a delay. Telephone interview with Resident #5's primary care provider (PCP) on 06/12/25 at 3:42pm revealed: -Resident #5's Gabapentin was managed by the pain clinic. -The resident took pain medications to manage chronic pain syndrome, lumbar radiculopathy (pinched nerve), chronic right and left hip pain, and chronic bilateral low back pain with right side sciatica (pain that radiates along the sciatic nerve from the lower back down the buttock and into the leg). Attempted telephone interview with Resident #5's pain clinic provider on 06/12/25 at 4:25pm was unsuccessful. _____ The facility failed to administer medications as ordered to 2 of 4 residents observed during the morning medication pass on 06/11/25. Resident #8 who had chronic obstructive pulmonary disease missed doses of an inhaler putting the resident at risk of increased breathing problems. Resident #9's topical pain gel was applied to his right elbow instead of the left elbow putting the resident at risk of breakthrough pain. There was a delay in Resident #3 receiving an antibiotic for a urinary tract infection and a failure to administer the complete course of the antibiotic, putting the resident at risk of a recurring infection; and a delay with increasing the dosage of an antipsychotic medication putting Resident #3 at risk of continuing to have the same delusions which could cause anxiety. Resident #5 missed doses of a muscle relaxer, a controlled substance for moderate to severe pain, and a medication for nerve pain causing the resident to miss medications used to manage her chronic pain	D 358		

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D 358	Continued From page 57 symptoms. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/13/25 for this violation.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record	D 367		

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D 367	Continued From page 58 reviews, the facility failed to ensure the medication administration records were accurate for 3 of 5 sampled residents (#2, #3, #5) including documentation for oxygen (#2), compression hose (#5), and a moisturizer for dry skin (#3). The findings are: 1. Review of Resident #5's current FL-2 dated 03/18/25 revealed diagnoses included type 2 diabetes mellitus, chronic obstructive pulmonary disease, hyperlipidemia, glaucoma, major depressive disorder, hypertension, congestive heart failure, and legal blindness. Review of Resident #5's current FL-2 dated 03/18/25 revealed there was an order for compression hose apply every morning and remove at bedtime. (Compression hose are used to prevent blood clots.) Review of Resident #5's primary care provider (PCP) visit note dated 04/29/25 revealed the resident was non-compliant with wearing compression hose. Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Compression Hose apply every morning and remove at bedtime scheduled at 7:00am and 7:00pm. -Compression Hose were documented as applied and removed each day except on 05/02/25 - 05/04/25 when it was documented as resident not wearing. -There was a duplicate entry for Compression Hose apply every morning and remove at bedtime scheduled at 7:00am and 7:00pm. -Compression Hose were documented as applied	D 367	10A NCAC 13F .1004(j) Medication Administration The facility will ensure the residents' medication administration record (MAR) will be accurate and include all the requirements in (j) (1-8) of rule area Medication Administration. Resident Care Coordinator and/or Designee will run Exception and Missed Medication Reports daily to review for correct documentation of all administered medications and treatments. Resident Care Coordinator/ Designee will conduct weekly chart audits To ensure medication and administration Records are matching and medication is being administrated in compliance with the orders. Resident Care Coordinator and Medication Technicians received In-Service on Rule area, Medication Administration on 6/16/2025. On 7/21/2025, the staff named above attended an In-Service training on Medication Administration which included the following: proper medication administration techniques, properly handling unclear orders, responsibility and accountability of medication aides for assuring medications and treatments are administered as ordered and properly documented, necessary steps to take when medication is not available, and the importance of establishing medication systems. Operational Manager and/or Designee will review Exception and Miss Medication Reports daily as a second check for correct documentation of administration of all medications. Correction Date – 7/21/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

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D 367	Continued From page 59 and removed each day except on 05/02/25, 05/04/25, 05/08/25, 05/09/25, 05/18/25, 05/22/25, 05/23/25, and 05/27/25 when it was documented as resident not wearing. Review of Resident #5's June 2025 eMAR dated 06/01/25 - 06/10/25 revealed: -There were two duplicate entries for Compression Hose apply every morning and remove at bedtime scheduled at 7:00am and 7:00pm. -Compression Hose were documented as applied each day from 06/01/25 - 06/10/25 and removed each day from 06/01/25 - 06/09/25 for both entries. Interview with a medication aide (MA) on 06/11/25 at 1:53pm revealed: -Resident #5 never wore compression hose. -The resident refused to wear compression hose. -She could not explain why documentation on the eMAR indicated the resident wore compression hose on most days. -She stated the eMAR was not accurate. Observation of Resident #5 on 06/12/25 at 12:40pm revealed both of the resident's ankles were swollen. Interview with Resident #5 on 06/12/25 at 12:40pm revealed: -She had been measured for compression hose twice but she did not like to wear them. -She tried them on but the compression hose were too tight. -She never wore the compression hose. -Her ankles were always swollen. Interview with the Resident Care Coordinator (RCC) on 06/12/25 at 2:54pm revealed:	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

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D 367	Continued From page 60 -The MAs should document Resident #5's compression hose as refused on the eMAR if the resident was refusing the hose and notify her. -The MAs should not document the compression hose as being applied if the compression hose were not being applied. 2. Review of Resident #3's current FL-2 dated 01/13/25 revealed: -Diagnoses included unspecified dementia, heart failure, hypothyroidism, hyperlipidemia, chronic obstructive pulmonary disease, and age-related osteoporosis. -There was an order for Cerave Cream apply a thin layer topically to the trunk for xerosis (abnormally dry skin) one daily. (Cerave Cream is a topical moisturizer used to treat and prevent dry skin.) Review of Resident #3's May 2025 - June 2025 electronic medication administration records (eMARs) revealed: -There was an entry for Cerave Cream apply to trunk for xerosis every day scheduled at 7:00am. -Cerave Cream was documented as administered daily from 05/01/25 - 06/12/25. Observation of Resident #3's medications on hand on 06/11/25 at 2:13pm revealed: -There was a one-pound jar of Cerave Cream dispensed on 01/16/25 with instructions to apply to trunk for xerosis every day. -None of the Cerave Cream in the one-pound jar had been used. Review of Resident #3's pharmacy dispensing records for April 2025 - June 2025 revealed no documentation of any Cerave Cream being dispensed.	D 367		

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D 367	Continued From page 61 Telephone interview with the Quality Assurance Representative at the facility's contracted pharmacy on 06/12/25 at 5:21pm revealed they dispensed a one-pound jar of Cerave Cream on 01/16/25. Interview with Resident #3 on 06/12/25 at 5:19pm revealed: -The MAs did not put any cream on her body, not even when she got her showers. -Her skin was dry and itchy. Interview with a medication aide (MA) on 06/11/25 at 2:13pm revealed: -The one-pound jar of Cerave Cream for Resident #3 was the only jar available for the resident. -Resident #3 did not usually refuse any medications. -She had no explanation as to why the Cerave Cream dispensed on 01/16/25 had not been used. -She could not explain why Cerave was documented as administered on the eMARs when none have been used from the only container dispensed. Interview with the Resident Care Coordinator (RCC) on 06/12/25 at 3:24pm revealed: -The MAs should administer the Cerave Cream daily as ordered. -The MAs should not document the Cerave Cream was administered if it was not administered. -The eMARs should be accurate. 3. Review of Resident #2's current FL-2 dated 03/27/25 revealed diagnoses included supraventricular tachycardia, hypertension, anxiety disorder, hyperlipidemia, and major	D 367		

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	HAL047014	A. BUILDING: _____ B. WING _____	R-C 06/13/2025

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D 367	Continued From page 62 depressive disorder. Review of Resident #2's signed physician's orders dated 03/27/25 revealed there was an order for Oxygen at 2L/minute, via nasal cannula as needed for shortness of breath. Review of Resident #2's May 2025 Treatment Administration Records (TAR) revealed: -There was an entry for oxygen at 2L/minute, via nasal cannula as needed for shortness of breath. -There was no documentation oxygen at 2L/minute was administered from 05/01/25 to 05/31/25. Review of Resident #2's June 2025 TAR revealed: -There was an entry for oxygen at 2L/minute, via nasal cannula as needed for shortness of breath. -There was no documentation oxygen at 2L/minute was administered from 06/01/25 to 06/11/25. Observation of Resident #2's on 06/12/25 at 8:57am revealed: -She was lying in bed with the oxygen nasal tube attached to her nose. -The oxygen concentrator was turned off. Interview with Resident #2 on 06/12/25 at 8:57am revealed: -She did use her oxygen all the time. -She used her oxygen while she was in bed at night. -She was using it now because she walked from the dining room to her room and was out of breath. Interview with a medication aide (MA) on 06/12/25 at 9:34am revealed Resident #2's	D 367		

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D 367	Continued From page 63 oxygen was as needed. Interview with the Resident Care Coordinator (RCC) on 06/12/25 at 2:16pm revealed: -The MAs should ask Resident #2 if she needed her oxygen. -When Resident #2 used her oxygen, the MAs should document on the TAR. -She expected the MAs to document when they administered Resident #2's oxygen. -She was not aware the MAs did not document when they administered Resident #2's oxygen. Interview with the Manager/Operations Specialist on 06/12/25 at 3:17pm revealed: -She expected the MAs to ask Resident #2 if she needed her oxygen. -She expected the MAs to check on Resident #2 if they administered her oxygen or the nasal tube from the oxygen was attached to her nose.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 1 of 3 residents (#5) sampled with orders for a controlled substance used to treat	D 392		

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D 392	Continued From page 64 moderate to severe pain and a medication used to treat nerve pain. The findings are: Review of Resident #5's current FL-2 dated 03/18/25 revealed diagnoses included type 2 diabetes mellitus, chronic obstructive pulmonary disease, hyperlipidemia, glaucoma, major depressive disorder, hypertension, congestive heart failure, and legal blindness. a. Review of Resident #5's current FL-2 dated 03/18/25 revealed an order for Oxycodone / Acetaminophen(APAP) 7.5/325mg 1 tablet every 6 hours for pain. (Oxycodone/APAP is a controlled substance used to treat moderate to severe pain.) Review of Resident #5's pharmacy dispensing records for April 2025 - June 2025 revealed: -There were 120 Oxycodone/APAP 7.5/325mg tablets dispensed on 04/05/25. -There were 120 Oxycodone/APAP 7.5/325mg tablets dispensed on 05/05/25. -There were 120 Oxycodone/APAP 7.5/325mg tablets dispensed on 06/04/25. Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone/APAP 7.5/325mg 1 tablet every 6 hours for chronic pain scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm. -Oxycodone/APAP 7.5/325mg was documented as not administered at 6:00pm on 05/05/25 due to the medication reordered, waiting for medication. Review of Resident #5's June 2025 eMAR dated	D 392		

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D 392	Continued From page 65 06/01/25 - 06/10/25 revealed: -There was an entry for Oxycodone/APAP 7.5/325mg 1 tablet every 6 hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm. -Oxycodone/APAP 7.5/325mg was documented as administered from 8:00am on 06/01/25 - 12:00pm on 06/10/25. Observation of Resident #5's medications on hand on 06/11/25 at 2:00pm revealed: -There was a supply of Oxycodone/APAP 7.5/325mg tablets dispensed on 05/30/25 with instructions to take 1 tablet every 6 hours. -There were 93 of 120 tablets remaining. Review Resident #5's controlled substance (CS) logs for May 2025 - June 2025 revealed: -There was no Oxycodone/APAP documented as administered and declined from the CS log for 05/05/25 at 6:00pm. -There was a blank entry on the May 2025 CS log between the entries for 05/07/25 at 12:00pm and 7:00pm and the count skipped from 113 to 111 with no accounting for the decline. -There was another blank entry between entries for 05/08/25 at 12:00pm and 05/09/25 at 12:00pm and the count skipped from 108 to 106 with no accounting for the decline. -There was no documentation of any dose of Oxycodone/APAP being documented and declined on the CS log from 12:00am on 05/13/25 - 12:00pm on 05/16/25, for a total of 15 doses not documented on the CS log. -There was an entry for 05/16/25 at 12:00am declined from the count after two entries for 05/17/25, leaving a balance of 88. -The next entry dated 05/17/25 at 1:00pm showed a balance of 73 but the entry above showed a balance of 88. -The MA's signature on these entries did not	D 392		

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D 392	Continued From page 66 match the same MA's signature on other entries. -There was no Oxycodone/APAP documented as administered and declined from the CS log for 06/07/25 at 6:00pm. -Oxycodone/APAP 7.5/325mg was not administered on 05/05/25 and 06/07/25 at 6:00pm. -There was a duplicate entry for 06/08/25, one for 7:00pm and one for 6:00pm signed by two different MAs but both declined from the CS count. -The last entry on the June 2025 CS log was 06/11/25 at 12:00pm with a balance of 93 tablets. Interview with Resident #5 on 06/12/25 at 12:40pm revealed: -The facility sometimes ran out of her Oxycodone/APAP. -She thought they usually got in back in stock later the same day.. -Most of the time if they were out of the Oxycodone/APAP, she was still able get Gabapentin (used for nerve pain) so that helped control her pain when she was out of Oxycodone/APAP. Interview with a medication aide (MA) on 06/12/25 at 5:50pm revealed: -The MAs were supposed to document the eMAR and CS logs when a controlled substance was administered. -The handwriting on the CS log for the entries on 05/16/25 and 05/17/25 were not her signature. -She did not know who documented those entries with her name. -The MAs were supposed to do CS counts when they changed shifts but sometimes the second shift MAs would not count with her when she came on third shift because the second shift MAs would say they had to leave.	D 392	10A NCAC 13F .1008(a) Controlled Substances The facility will ensure maintaining a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such order that there can be accurate reconciliation of the controlled substances. The facility conducted a comprehensive reconciliation of all controlled substances for Resident #5 and all other residents with controlled substances orders. All blank entries, skipped counts, and duplicate entries on Resident # 5 control substance logs were immediately investigated and corrected with appropriate explanations. Medication Aides will have a strict policy of requiring two Medication Aides to count and sign-off on all controlled substances at every shift change. This will include verifying the physical count the controlled substance log and Quick Mar.	

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D 392	Continued From page 67 Interview with the Special Care Coordinator (SCC) on 06/12/25 at 2:17pm revealed: -She helped administer medications at times. -She did not recognize the handwriting of the signature on the entries for 05/16/25 and 05/17/25. -She was not sure why there were some duplicate entries and blank entries on the CS logs for the Oxycodone/APAP. Refer to interview with the Special Care Coordinator (SCC) on 06/12/25 at 2:17pm. Refer to interview with the RCC on 06/12/25 at 2:54pm. Refer to interview with the Manager/Operations Specialist on 06/12/25 at 4:36pm. b. Review of Resident #5's current FL-2 dated 03/18/25 revealed an order for Gabapentin 600mg 1 tablet 3 times a day. (Gabapentin is used to treat nerve pain.) Review of Resident #5's pharmacy dispensing records for April 2025 - June 2025 revealed: -There were 90 Gabapentin 600mg tablets dispensed on 04/19/25. -There were 90 Gabapentin 600mg tablets dispensed on 05/20/25. Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Gabapentin 600mg 1 tablet 3 times a day scheduled at 7:00am, 1:00pm, and 7:00pm. -Gabapentin was documented as not being administered from 7:00am on 05/19/25 - 7:00am	D 392	Medication Aides will be required to document controlled substances administration immediately at the time of administration on both the Quick Mar and the Controlled Substance log, ensuring no delayed or "after the fact" entries. The facility will reinforce its policies on secure storage and access to controlled substances. All medication aides will receive mandatory training on the immediate reporting protocol for any discrepancies found during controlled substance counts or reconciliation to the Resident Care Coordinator, Supervisor in Charge of the shift, and the Administrator. Any staff not adhering to the controlled substances policies will have disciplinary actions presented based on the findings of an investigation. standardized audit tool will be developed and utilized by the Resident Care Coordinator/Designee and the Supervisor in charge/Designee to conduct daily reconciliation of the controlled substance logs. This audit will specifically look for blank entries, skipped counts, duplicate entries, and signature discrepancies. The Resident Care Coordinator/supervisor in charge/designee will conduct weekly spot checks of controlled substances and the documentation. The Resident Care Coordinator/Designee and the Administrator/Designee will review reports on controlled substance reconciliation, monthly and any identified discrepancies will be investigated. **Correction Date – 7/21/25**	

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D 392	Continued From page 68 on 05/20/25 due to waiting for meds, should be in tonight. -There were 4 doses of Gabapentin not documented as administered in May 2025. Review Resident #5's controlled substance (CS) logs for May 2025 and June 2025 revealed: -There was no Gabapentin documented as administered from 7:00pm on 05/08/25 - 1:00pm on 05/09/25 but the count was declined for those doses. -There was an entry for 05/15/25 at 7:00am with a balance of 11 but the next entry for 05/15/25 at 1:00pm declined the count to 9 tablets. -There was no Gabapentin documented as administered and declined from the CS log from 7:00pm on 05/18/25 - 7:00pm on 05/20/25, for a total of 7 missed doses in May 2025. -There were duplicate entries for 05/28/25 at 7:00am but both entries declined the count by 1 tablet each. -On 06/11/25 at 1:00pm, there was a balance of 23 tablets. Observation of Resident #5's medications on hand on 06/11/25 at 2:00pm revealed: -There was a supply of Gabapentin 600mg tablets dispensed on 05/20/25 with instructions to take 1 tablet 3 times a day. -There were 23 of 90 tablets remaining. Interview with Resident #5 on 06/12/25 at 12:40pm revealed: -The facility sometimes ran out of her Gabapentin. -She thought they usually got in back in stock later the same day. -Most of the time if they were out of the Gabapentin, she was still able get Oxycodone/Acetaminophen (a controlled	D 392		

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D 392	Continued From page 69 substance for moderate to severe pain) so that helped control her pain when she was out of Gabapentin. Interview with a medication aide (MA) on 06/12/25 at 5:50pm revealed: -The MAs were supposed to document the eMAR and CS logs when a controlled substance was administered. -She had no explanation for the discrepancies with Resident #5's CS logs for Gabapentin. Refer to interview with the Special Care Coordinator (SCC) on 06/12/25 at 2:17pm. Refer to interview with the RCC on 06/12/25 at 2:54pm. Refer to interview with the Manager/Operations Specialist on 06/12/25 at 4:36pm. Interview with the Special Care Coordinator (SCC) on 06/12/25 at 2:17pm revealed: -The MAs were supposed to document the eMARs and the CS logs when controlled substances were administered. -The MAs counted the controlled substances when they changed shifts. -If the count did not match, it was usually because the MAs miscounted or misread the previous number listed on the CS logs. -She was not sure why some of the entries on the CS logs were out of order; it could be late entries that they forgot to document at the time it was administered. -There should not be blanks on the CS logs. -If there were discrepancies with the CS logs, the MAs should notify her or the Resident Care Coordinator (RCC).	D 392		

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D 392	Continued From page 70 Interview with the RCC on 06/12/25 at 2:54pm revealed: -The MAs should document the eMARs and the CS logs when administering controlled substances. -She was new at the facility, and she thought there was a system to check the CS logs for accuracy but she had not participated in those checks yet. -The MAs counted the controlled substances and the change of each shift. -If there was a discrepancy, the MAs should notify the supervisor on duty, who would then notify her. -There had been no drug diversion to her knowledge. -She thought the MAs might be documenting on the CS log after the fact instead of when the controlled substances were actually administered. Interview with the Manager/Operations Specialist on 06/12/25 at 4:36pm revealed: -The MAs on shift count the controlled substances with the oncoming MAs. -The MAs were supposed to check the number on hand and if it did not match the CS logs, the MAs should let the Administrator, SCC, the RCC, or her know about it. -No concerns had been reported about the CS counts. -There was currently no system in place to compare the CS logs with the eMARs.	D 392		
D 435	10A NCAC 13F .1202 Disposal Of Resident Records 10A NCAC 13F .1202 Disposal Of Resident Records After a resident has left an adult care home or	D 435		

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D 435	Continued From page 71 died, the resident's records shall be filed in the facility for at least one year and then stored for at least two more years. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled closed resident records (#6) were filed in the facility for at least one year and then stored for at least two more years after the resident had died. The findings are: Review of a handwritten list of resident admissions and discharges for the facility from 2023 - 2025 provided on 06/10/25 revealed: -Resident #6 was admitted to the facility on 09/12/23. -Resident #6's discharge date (deceased) was 03/22/24. Review of Resident #6's closed record provided by the facility on 06/10/25 revealed: -There was no FL-2. -There was no Resident Register. -There was no assessment and care plan. -There was no documentation of immunizations or tuberculosis (TB) testing. -There were no medication administration records. -There was no documentation of receipt of: contract for services, accommodations, and rates; house rules, declaration of residents' rights, grievance procedures, or civil rights statement.	D 435	10A NCAC 13F .1202 Disposal of Resident Records The facility will ensure that after a resident has left the facility or died, that the record will be filed in the facility for at least one year and then stored for at least two more years. All closed resident records will be stored in a designated, secure, dry, climate-controlled areas that are regularly inspected for Environmental hazards. The facility will educate relevant staff on the record retention procedure and the rules on the disposal of records. The Administrative Assistant will be assigned responsibility overseeing record retention and ensuring compliance with state regulations. The Administrative Assistant will conduct monthly inspections of the record storage area for environmental integrity and organization. **Correction Date 7/21/25**	

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D 435	Continued From page 72 Interview with the Manager/Operations Specialist on 06/11/25 at 10:45am revealed: -She could not locate the rest of Resident #6's record. -She had "looked everywhere". -She was unable to locate the resident's FL-2, Resident Register, or Assessment and Care Plan. -She had the resident's former hospice provider fax some hospice records and she was also printing some electronic primary care provider (PCP) visit notes. -She was unable to print medication administration records because the facility used a different contracted pharmacy provider when the resident resided at the facility. A second interview with the Manager/Operations Specialist on 06/12/25 at 4:36pm revealed: -She had been unable to locate the rest of Resident #6's record. -There was a water leak in the storage room where the facility maintained closed records. -There were multiple records damaged and destroyed due to the water leak. -The rest of Resident #6's record may have been destroyed in the water leak since she had been unable to locate it.	D 435		