

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: fc1032171	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/02/2026
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

SPRINGDALE ASSISTED LIVING

**4315 HOLDER ROAD
DURHAM, NC 27703**

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on June 02, 2026.	C 000		
C 202	10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination, and Immunizations (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#1) had completed tuberculosis (TB) testing in compliance with the control measures of the Commission for Health Services. The findings are: Review of Resident #1's current FL2 dated 11/12/25 revealed diagnoses included essential hypertension, chronic kidney disease Stage 3, iron deficiency anemia, and Type 2 diabetes mellitus. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 11/19/24.	C 202		

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

TITLE

(X6) DATE

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NAME OF PROVIDER OR SUPPLIER SPRINGDAILE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 4315 HOLDER ROAD DURHAM, NC 27703		
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C 202	<p>Continued From page 1</p> <p>Review of the Centers for Disease Control and Prevention (CDC) guidelines for testing for TB in residents residing in assisted living facilities revealed a single Quantiferon blood test or 2 step TB skin test should be performed to rule out the presence of TB.</p> <p>Review of Resident #1's documentation for TB skin tests revealed: -A TB skin test was administered on 11/15/24 and read as negative on 11/18/24. -There was no documentation the resident had received a second step TB skin test or Quantiferon blood test for TB since admission to the facility.</p> <p>Interview with Resident #1 on 06/03/26 at 4:00pm revealed she did not recall if she had a test for TB in the past.</p> <p>Interview with the Administrator on 06/02/26 at 3:40pm revealed: -All residents should have documentation of a two-step TB test prior to admission to the facility, or the facility was responsible for ensuring a two-step TB test was performed at admission. -She was the current Administrator, however, the former Administrator was responsible for reviewing the residents' TB test results upon admission to ensure compliance with the TB requirements when Resident #1 was admitted. -She was responsible for ensuring all residents had a 2 step TB skin test upon admission to the facility. -She was not aware that the second step TB skin test had not been completed for Resident #1. -She thought Resident #1 had a second step TB skin test after admission in November 2024. -She was unable to locate documentation of a</p>	C 202			

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C 202	Continued From page 2 second TB skin for Resident #1 in the documents available for review.	C 202			
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.	C 335			

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C 335	<p>Continued From page 3</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 3 of 4 residents (#1, #2, and #3).</p> <p>The findings are:</p> <p>Observation of the facility on 06/02/26 at 8:30am revealed:</p> <ul style="list-style-type: none"> -The dining room table had four place settings. -There were no residents present at the table. -The Supervisor-in-Charge (SIC) prepared breakfast in the kitchen area adjacent to the dining room. -Three of the place setting had a small paper cup with no lid that contained various medications. -None of the paper cups were labeled with the residents' name. -There was no other information on the paper cups that included the medications that were in the cups. -The SIC plated the breakfast meals and placed the meals at each place setting. -The SIC called the residents to breakfast. -The SIC told each of the 3 residents to be sure to take their medications with breakfast. -The SIC cleaned the kitchen area as the residents were eating breakfast. -The SIC did not observe each resident taking their medications. <p>1. Review of Resident #1's current FL2 dated 11/12/25 revealed: -Diagnoses included Type 2 diabetes mellitus,</p>	C 335			

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C 335	<p>Continued From page 4</p> <p>chronic kidney disease stage 3, iron deficiency anemia, stenosis of right carotid artery, elevated myocardial infarction, legally blind, and essential hypertension.</p> <p>-Medications ordered on the current FL2 dated 11/12/25 as follows:</p> <p>-Isosorbide extended release (used to treat heart angina) 90mg daily;</p> <p>-Januvia (used to treat diabetes) 50mg daily;</p> <p>-Clopidogrel (used to thin blood) 75mg daily;</p> <p>-Aspirin enteric coated (used to thin blood) 81mg daily;</p> <p>-Sodium bicarbonate (used to treat diabetes and kidney disease) 650mg three times a day;</p> <p>-Metoprolol extended release (used to treat blood pressure and heart rate) 25mg daily.</p> <p>Review of Resident #1's physician's order dated 02/11/26 revealed an order for fenofibrate (used to treat elevated cholesterol and triglycerides) 54mg daily.</p> <p>Review of Resident #1's June 2026 medication administration record (MAR) from 06/01/26 to 06/02/26 revealed documented administration on 06/02/26 at 8:00am for isosorbide extended release 90mg, Januvia 50mg, clopidogrel 75mg, aspirin enteric coated 81mg, sodium bicarbonate 650mg, metoprolol extended release 25mg and fenofibrate 54mg.</p> <p>Interview with Resident #1 on 06/02/26 at 4:00pm revealed:</p> <p>-The residents had assigned seats at the dining room table.</p> <p>-The morning medications were placed by the SIC in front of her meal plate.</p> <p>-She took several morning medications.</p> <p>-She routinely took her medications during her meal.</p>	C 335		

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C 335	<p>Continued From page 5</p> <p>Refer to the interview with the SIC on 06/02/2026 at 4:20pm.</p> <p>Refer to the interview with the Administrator on 06/02/26 at 4:45pm.</p> <p>2. Review of Resident #2's current FL2 dated 01/14/26 revealed: -Diagnoses included major neurocognitive disorder, history of CVA (cerebrovascular accident), benign prostatic hyperplasia (BPH), anxiety, history of asthma gastroesophageal reflux, and essential hypertension. -Medications ordered on the current FL2 dated 01/14/26 as follows: -Finasteride (used to treat BPH) 5mg every morning; -Tamsulosin (used to treat BPH) 0.4mg every morning; -Escitalopram (used to treat anxiety) 10mg every morning; -Memantine (used to treat mental disorders) 5mg every morning; -Aspirin enteric coated (used to thin blood) 81mg every morning; -Amlodipine (used to treat hypertension) 10 mg every morning; -Lisinopril (used to treat hypertension) 40mg every morning.</p> <p>Review of Resident #2's physician's order dated 02/11/26 revealed an order for cetirizine (used to treat allergies) 10mg every day.</p> <p>Review of Resident #2's June 2026 medication administration record (MAR) from 06/01/26 to 06/02/26 revealed documented administration on 06/02/26 at 8:00am for finasteride 5mg, tamsulosin 0.4mg, escitalopram 10mg,</p>	C 335			

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C 335	<p>Continued From page 6</p> <p>memantine 5mg, aspirin enteric coated 81mg, amlodipine 10 mg, and lisinopril 40mg.</p> <p>Interview with Resident #2 on 06/02/26 at 4:10pm revealed:</p> <ul style="list-style-type: none"> -The residents had assigned seats at the dining room table. -The morning medications were placed by the SIC in front of his meal plate. -He took several morning medications. -He routinely took his medications during his meal. -He had been taking his medications the same way for several months. <p>Refer to the interview with the SIC on 06/02/2026 at 4:20pm.</p> <p>Refer to the interview with the Administrator on 06/02/26 at 4:45pm.</p> <p>3. Review of Resident #3's current FL2 dated 03/11/26 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included acute encephalopathy, cellulitis, osteomyelitis, elevated Creatine Phosphokinase (CPK), and sepsis. -Medications ordered on the current FL2 dated 03/11/26 as follows: -Gabapentin (used to treat nerve pain) 300mg 3 times a day; -Sennosides-docusate (used to treat constipation) 8.6-50mg 2 tablets twice a day; -Thiamin (a vitamin B-1 supplement) 100mg daily; -Tamsulosin (used to treat blood pressure) 0.4mg daily; <p>Review of Resident #3's physician's order dated 03/11/26 revealed an order for vitamin B-12 (a vitamin supplement) 1000mcg every day.</p>	C 335			

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C 335	<p>Continued From page 7</p> <p>Review of Resident #3's physician's order dated 03/27/26 revealed an order for sertraline (used to treat anxiety or depression) 50mg every day.</p> <p>Review of Resident #3's June 2026 medication administration record (MAR) from 06/01/26 to 06/02/26 revealed documented administration on 06/02/26 at 8:00am for gabapentin 300mg, sennosides-docusate 8.6-50mg 2 tablets, thiamin 100mg daily, tamsulosin 0.4mg, vitamin B-12 1000mcg, and sertraline 50mg.</p> <p>Interview with Resident #3 on 06/02/26 at 4:05pm revealed:</p> <ul style="list-style-type: none"> -The residents had assigned seats at the dining room table. -The morning medications were placed by the SIC in front of her meal plate. -She took several morning medications. -She had been taking his medications the same way for several months. -She was not sure when or where the medications were prepared for her. -She did not know all her medications but the paper cup had about the same amount of medication each morning. <p>Refer to the interview with the SIC on 06/02/2026 at 4:20pm.</p> <p>Refer to the interview with the Administrator on 06/02/26 at 4:45pm.</p> <p>Interview with the SIC on 06/02/2026 at 4:20pm revealed:</p> <ul style="list-style-type: none"> -She had been employed at the facility since September 2025. -Residents had assigned seats at the dining room table and always sat at their assigned seat during 	C 335		

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C 335	<p>Continued From page 8</p> <p>each meal.</p> <p>-She routinely prepared the residents medications in the SIC's office before she began preparing breakfast.</p> <p>-One resident attended a day program and received her medications at the time she prepared all the medications.</p> <p>-She obtained the residents' medication storage tote from the locked medication storage closet, and compared the medication orders on the MAR as she placed the residents' medications in the paper cups.</p> <p>-She prepared each resident's medications, one at a time, in the medication room; put residents' initials on the bottom side of the paper cup and kept the medications in the SIC office until she placed the paper cups at each resident's assigned place at the dining room table.</p> <p>-She did not know medications prepared in advance had to have the name of each medication on the container, the resident name, and be in a covered container to protect the medication from contamination and documented for administration after the resident had taken the medication.</p> <p>-She documented administration on the MAR while she was preparing each resident's medications.</p> <p>-She checked the residents' paper medication cups after the meal to ensure the residents had taken their medications.</p> <p>Interview with the Administrator on 06/02/26 at 4:45pm revealed:</p> <p>-The facility policy for medication administration was to prepare resident's medication one at a time, administer the medication, document on the MAR and move to the next resident.</p> <p>-She did not know the SIC was preparing medication in advance of the meal and placing at</p>	C 335		

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C 335	Continued From page 9 the residents' plated meals.	C 335			