STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 April 15-16, 2025.	D 000		
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 reviews, the facility failed to provide a safe and clean environment related to the presence of live and dead cockroaches and cockroach excrement throughout the facility, and an environment free from hazards as evidenced by unsecured personal care products in residents' rooms on the Special Care Unit (SCU). The findings are: 1. Review of the United States Environmental Protection Agency's (EPA) cockroach information sheet dated 03/13/25 revealed: -Cockroaches and their droppings, saliva, eggs, and outer coverings can cause allergic reactions	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 1	D 079		

to humans, particularly those with a history of asthma or other respiratory conditions.
-Cockroaches carry bacteria on their bodies, which could cause salmonella, staphylococcus, or streptococcus if cockroaches come in contact with food.

Review of the facility's census on 04/15/25 revealed there were 63 residents in the facility.

Review of the facility's March 2025 pest control record dated 03/31/25 revealed:
-The type of service performed was regular commercial monthly service.
-The kitchen, janitor's closet and 34 resident rooms were treated for general pests.

Observation of the hallway near the canteen room on 04/15/25 at 8:28am revealed there was a cockroach crawling on the floor.

Second observation of the hallway near the storage room on 04/16/25 at 8:02am revealed there was a cockroach crawling on the floor.

Observation of the common bathroom outside of the Special Care Unit (SCU) on 04/15/25 from 8:30am to 8:35am revealed:
-There were 3 dead cockroaches in the shower stall.
-There were 2 dead cockroaches near the toilet.
-There was 1 dead cockroach under the sink.
-There was a live cockroach crawling across the floor.

Second observation of the common bathroom outside of the SCU on 04/16/25 from 7:57am to 8:00am revealed:
-There were 3 dead cockroaches in the shower stall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 2	D 079		

-There were 2 dead cockroaches near the toilet.
-There was 1 dead cockroach under the sink.

Observation of room 37 on 04/15/25 at 8:55am revealed:
-In the second left side dresser drawer, there was roach excrement in the corners of the drawers, numerous dead cockroaches throughout the drawer, and dead cockroach fragments on the resident's clothing.
-There was 1 dead cockroach on the floor near the dresser.
-There was 1 dead cockroach on the floor of the bathroom.
-There were remnants of a dead cockroach on the wall in the bathroom.

Interview with a resident in room 37 on 04/15/25 at 8:50am revealed:
-He saw cockroaches in the facility daily.
-He frequently saw cockroaches in his room, especially in the bathroom.
-He killed a cockroach in the bathroom in his room this morning.
-He was tired of seeing cockroaches in the facility.
-He saw cockroaches in the dining room almost every day.
-A housekeeper usually cleaned his room twice a week.
-He was unsure the last time an exterminator was at the facility.
-When the exterminator sprayed his room, he only sprayed insecticide near the heating and air conditioning unit and nowhere else.

Interview with a second resident in room 37 on 04/15/25 at 8:55am revealed:
-The facility continued to have cockroaches.
-He saw an exterminator at the facility a few

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 3	D 079		

weeks ago.
-The exterminator only sprayed insecticide near the heating and air conditioning unit in his room.
-The housekeeper cleaned his room 2-3 times a week.
-No one at the facility assisted him with cleaning his dresser drawers.
-He did not use the items in his dresser because of the cockroaches and cockroach excrement.

Observation of room 30 on 04/15/25 at 9:36am revealed:
-There were 2 live cockroaches crawling inside the top left dresser drawer.
-There was cockroach excrement in the corners of the top left dresser drawer.
-There were crumbs and pieces of food on the floor in front of the dresser.

Interview with a resident in room 30 on 04/15/25 at 11:13am revealed:
-He continued to see cockroaches in his room, especially around the dresser.
-He was unsure the last time he saw an exterminator at the facility.
-No one at the facility had cleaned out his dresser drawers recently.
-He was unsure of the last time his dresser drawers were cleaned.
-The housekeepers usually cleaned his room 2-3 times each week.

Observation of room 51 on the SCU on 04/15/25 at 9:35am revealed:
-There was a dead cockroach lying in the freezer a resident's mini refrigerator.
-There was cockroach excrement sitting in a corner of two dresser drawers.
-There was a dead cockroach sitting inside of a styrofoam cup inside of a dresser drawer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 4 Interview with the resident in room 51 on 04/15/25 at 9:35am revealed: -The facility had a cockroach problem for a while now. -She saw cockroaches in her mini refrigerator, the freezer, and in her dresser drawers every day. -She cleaned the dead cockroaches and excrement out of her refrigerator on 04/14/25 but had not cleaned the cockroach lying in her freezer. -Her personal items were in boxes on the floor because of the cockroaches inside the dresser drawers. -She had to clean the dead cockroaches and excrement from time to time and no staff cleaned her room of cockroaches or the excrement. -She told a staff member about six months ago about the cockroaches and the excrement but could not recall who she told. -An exterminator came to the facility to spray but she could not recall the last time they came out. Observation of room 57 on the SCU on 04/15/25 at 10:09am revealed: -There was a dead cockroach with excrement sitting inside of a dresser drawer. -There was a dead cockroach sitting inside of the second dresser drawer. Observation of room 44 on SCU on 04/15/25 at 10:13am revealed: -There were dead cockroaches and cockroach excrement sitting inside of a dresser drawer -There was a dead cockroach sitting inside of the second dresser drawer. Interview with a personal care aide (PCA) on 4/15/25 at 11:15am revealed: -She was aware of the facility having a cockroach	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 5	D 079		

problem, but it had not been bad on the SCU side.
-She would scan for dead and alive cockroaches weekly.
-If she noticed an issue with live cockroaches, she would report it to the medication aide.

Interview with a second PCA on 4/16/25 at 9:50am revealed:
-She saw a live cockroach on the SCU side of the facility about a week ago in the hallway.
-She saw dead cockroaches on the floor in resident's rooms usually after the room had been exterminated.
-The PCA was responsible for sweeping dead cockroaches or excrements.
-There had been times that she had noticed dead cockroaches in resident's dresser drawers but not in the last month.
-The PCAs were responsible for checking for any cockroaches daily.
-She would report it to the MA when she saw live cockroaches.

Interview with a housekeeper on 4/16/25 at 9:40am revealed:
-He saw a live cockroach here and there.
-He was not aware of dead cockroaches or excrement in the resident's dresser drawers.
-He was told to clean the resident's closets and personal refrigerator of any rodents, but he did not recall that he was responsible for cleaning resident's dresser drawers.
-The exterminator came out about a month ago but he could not recall the exact date.
-He was not given instructions on who to tell about the cockroaches but he told the PCA so they could tell upper management.

Interview with a second housekeeper on 04/16/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 6 at 9:45am revealed: -The housekeepers rotated halls, and she did not always work on the same hall. -She cleaned each resident's room daily on the hall she was assigned. -The common bathrooms were cleaned daily. -Daily cleaning of rooms consisted of sweeping, mopping, wiping surfaces with disinfectant spray, and cleaning the toilets and sinks. -Some residents stored food in their rooms and spilled food on the floors, which could cause cockroaches -The cockroach excrement and dead cockroaches were difficult to clean and did not come off the walls easily. -The facility did not have a cleaning schedule for cleaning the residents' dresser drawers. -Some residents did not want the housekeepers to clean inside their dressers. -She had not seen any live cockroaches recently. Interview with the Maintenance Director on 04/16/25 at 2:50pm revealed: -The facility was scheduled for monthly pest control services. -Daily cleaning for each resident's room included sweeping, mopping, trash removal, checking the bathroom, and cleaning any spills. -Deep cleaning was performed weekly in each resident's room and included sweeping, mopping, dusting, moving furniture, taking out trash, and cleaning all surfaces of the bathroom. -He provided the residents with plastic storage containers to store any food in their rooms. -Some residents continued to eat in their rooms and drop food, which could continue to cause cockroaches. -The housekeepers attempted to clean out the drawers in residents' rooms, but some residents refused.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 7	D 079		

-The housekeepers cleaned the common bathrooms daily.
-If the facility staff saw dead cockroaches, the dead cockroaches should be cleaned up immediately.
-If the facility saw cockroach excrement, the excrement should be cleaned with disinfectant immediately.
-If the facility staff saw live cockroaches, they were to report the sightings to him so he could have the exterminator treat those areas.

Interview with the Resident Care Coordinator (RCC) on 4/15/25 at 11:35am revealed:
-She was aware of a cockroach problem on the SCU side.
-The housekeepers, PCAs, and MAs were all responsible for checking for cockroaches and cleaning when they saw dead cockroaches or excrement.
-An exterminator came out to spray but she could not recall the last visit.
-Staff was responsible for reporting any cockroach activity to her or the Administrator.

Interview with the Administrator on 04/16/25 at 12:10pm revealed:
-The pest control technician treated the facility for cockroaches monthly,
-The housekeepers cleaned residents' rooms and common bathrooms daily.
-Residents were provided with plastic storage containers to store food items in their rooms.
-If the facility staff saw dead cockroaches, the dead cockroaches should be cleaned up immediately.
-Any cockroach excrement should be cleaned immediately.
-The housekeepers should be checking the residents' dresser drawers and closets and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 8	D 079		

cleaning any dead cockroaches or cockroach excrement.
-The housekeepers should report to the Maintenance Director if any residents refused cleaning.

Telephone interview with the facility's pest control technician on 04/16/25 at 4:18pm revealed:
-He was currently treating the facility monthly for general pests, including cockroaches.
-The facility had not requested any additional treatments in addition to their monthly service.
-He treated resident rooms with reported cockroach activity, the kitchen, dining room, employee break rooms, and any areas that could be potential entry points for pests.
-If the facility staff saw dead cockroaches, the dead cockroaches should be swept up or cleaned from surfaces.
-He had not seen any live cockroaches in the facility in a couple of months, but did see some dead cockroaches when he came to the facility.
-It could take several months to eradicate cockroaches because the cockroaches often laid eggs and the eggs continued to hatch.
-Crumbs, spilled food, and how food was stored contributed to having cockroaches.

Attempted telephone interview with the facility's contracted primary care provider (PCP) on 04/16/25 at 2:34pm was unsuccessful.

2. Observation of room 53 on the Special Care Unit (SCU) on 04/15/25 at 10:03am revealed:
-There was a 4 ounce tube of zinc oxide paste skin protectant inside of a top dresser drawer.
-There was a 2 ounce tube of zinc oxide 20% cream skin protectant inside of a top dresser drawer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 9 Observation of room 60 on the SCU on 04/15/25 at 10:10am revealed there was a container of deodorant on the dresser with a warning label reading "Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away." Observation of room 40 on the SCU on 04/15/25 at 10:13am revealed: -On the right side of the dresser, there was a bottle of lotion and a tube of hair styling gel. -On the left side of the dresser, there was a bottle of hand sanitizer with a label reading "Do not use in the eyes. In case of contact, rinse eyes thoroughly with water. Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away." -On the left side of the dresser, there was a container of deodorant with a warning label reading "Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away." -On the left side of the dresser, there was a bottle of nail polish and a 24 ounce bottle of body wash. Interview with a personal care aide (PCA) on 4/15/25 at 11:15am revealed: -She was not aware of any tubes of cream in the resident's top dresser drawer. -No residents on the SCU hall could self-administer medications. Interview with a medication aide (MA) on 4/16/25 at 10:40am revealed: -She was not aware of any tubes of cream in a resident's top dresser drawer and was not sure why it was in a resident room. -There were several residents on the SCU who wandered and would go into other residents' rooms.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 10 -The MAs and PCAs were responsible for checking resident's rooms daily on the SCU for medications or anything that could be placed in the mouth and cause harm. Interview with the Resident Care Coordinator (RCC) on 4/15/25 at 11:35am revealed: -The MAs were responsible for walk-throughs during their rounds, daily and as often as every two hours, to be sure there were no personal hygiene items or medications in the residents' rooms and if found lock it up or dispose of it properly. -The PCAs were responsible for checking rooms, daily and as often as every two hours, to scan of the room to be sure no items of any kind were left. -The MAs and PCAs were responsible for reporting medications or personal items found to the RCC and she was responsible for reporting to the Administrator. Interview with Administrator on 4/15/25 at 3:50am revealed: -She was not aware of any tubes of cream in a resident's dresser drawer. -The staff made frequent "ingestible" checks of residents' rooms to check for "ingestible" items that could be harmful to the resident such as personal items, cleaning products, and medications.	D 079		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in	D 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 255	Continued From page 11 Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.	D 255		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 255	Continued From page 12	D 255		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (#2) with a pressure ulcer had a care plan updated within 10 days of a significant change in condition.

The findings are:

Review of Resident #2's current FL2 dated 03/06/25 revealed diagnoses included diabetes mellitus, coronary artery disease, hypertension, and kidney failure.

Review of Resident #2's facility progress note dated 03/11/25 revealed Resident #2 returned to the facility from a local rehabilitation facility.

Review of Resident #2's current care plan dated 12/05/24 revealed:
-Resident #2 required limited assistance with eating and toileting.
-Resident #2 required extensive assistance with ambulation, bathing, dressing, and grooming,
-Resident #2 required supervision with transfers.

Review of Resident #2's record revealed there were no other care plans available for review.

Review of Resident #2's home health agency notes revealed:
-On 03/14/25, the home health nurse performed a dressing change to a wound on Resident #3's sacral area (The sacral area is located at the lower base of the spine, above the buttocks).
-The wound was documented as a stage 3 pressure ulcer (Stage 3 pressure ulcers are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 255	Continued From page 13	D 255		

wounds that have progressed through the first 2 layers of the skin and into the fatty tissue).
-There was documentation of wound care performed by a home health nurse on 03/18/25, 03/20/25, 03/26/25, 03/28/25, 03/31/25, and 04/04/25.

Review of Resident #2's primary care provider's (PCP) order dated 04/14/25 revealed there was an order for a hospice referral.

Review of Resident #2's consultation report dated 04/14/25 revealed Resident #2 was treated at a local wound clinic for a stage 4 pressure ulcer (Stage 4 pressure ulcers are wounds that have progressed through the first 2 layers of the skin, through the fatty tissue, and into deeper tissues including muscles, ligaments, and tendons).

Interview with Resident #2 on 04/16/25 at 2:40pm revealed:
-The facility staff checked his blood sugar and administered his insulin.
-He had a pressure ulcer on his lower back.
-He tried to change positions often and keep pressure off the area.
-He tried to avoid sitting for long periods of time because it caused the sore to be painful.
-He was able to ambulate short distances, and he used his wheelchair if he became tired.
-The facility staff assisted him with bathing and dressing if he needed help.
-He started receiving hospice services on 04/15/25, and hospice would begin providing him assistance with bathing.

Interview with a medication aide (MA) on 04/16/25 11:10am revealed:
-The facility staff administered Resident #2's medications, checked his fingerstick blood sugar

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 255	Continued From page 14	D 255		

(FSBS) three times daily, and administered insulin once daily.
-Resident #2 had a pressure ulcer on his lower back and home health treated the area 2-3 times each week.
-Resident #2 started receiving hospice services on 04/15/25.
-Resident #2 was ambulatory or could propel himself in his wheelchair.
-Resident #2 could request assistance with bathing and dressing if needed.

Interview with the Resident Care Coordinator (RCC) on 04/16/25 at 11:40am revealed:
-She was responsible for completing the residents' care plans.
-Care plans were completed on admission, annually, and if the residents had a significant change.
-She was aware Resident #2 had a pressure ulcer.
-She was not aware a pressure sore was considered a significant change in condition.
-She had not updated Resident #2's care plan since he returned from the rehabilitation facility in March 2025

Interview with the Administrator on 04/16/25 at 12:10pm revealed:
-The RCC was responsible for completing the residents' care plans.
-Care plans were completed on admission, annually, and with a significant change in condition.
-If a resident had a significant change, their care plan should be updated within 10 days.
-She was aware Resident #2 had a pressure ulcer.
-She was aware a pressure ulcer was considered a significant change in condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 255	Continued From page 15 -The RCC should have completed Resident #2's care plan within 10 days of his return from the rehabilitation facility since he was readmitted to the facility with a pressure ulcer.	D 255		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#2) including a medication used to lower blood sugars. The findings are: Review of the Centers for Disease Control (CDC) Diabetes fact sheet dated 05/15/24 revealed: -Diabetes mellitus can affect nerves and blood vessels in a person's skin, causing poor circulation. -Hyperglycemia can cause changes in a person's skin such as dryness and increased risk of skin infections (Hyperglycemia is medical term for high blood sugar levels). -People with diabetes are more susceptible to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 16	D 358		

infections than those without diabetes.
-Bacteria can grow rapidly when a person's blood sugar level is too high, resulting in an infection.
-Hyperglycemia is caused by a person's diet, illnesses, or from not taking enough insulin (Insulin is an injectable medication used to control blood sugar levels).

Review of the facility's undated medication administration policy revealed medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders.

Review of Resident #2's current FL2 dated 03/06/25 revealed:
-Diagnoses included diabetes mellitus, coronary artery disease, hypertension, and kidney failure.
-There was an order for Lispro sliding scale insulin (SSI) 0-200=0 units, 201-250=2 units, 251-300=6 units, 301-350=8 units, 351-400=10 units (Lispro is a rapid acting injectable medication used to lower blood sugar at meals).
-There was an order for Lantus insulin 20 units subcutaneously daily (Lantus is a long acting injectable medication used to control blood sugar).
-There was an order to check fingerstick blood sugar (FSBS) prior to Lantus administration.

Review of Resident #2's facility progress note dated 03/11/25 revealed Resident #2 returned to the facility from a local rehabilitation facility.

Review of Resident #2's primary care provider's (PCP) order dated 03/12/25 revealed:
-There was an order to discontinue FSBS daily.
-There was an order to check FSBS before meals three times a day with SSI with parameters.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 17 Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS before meals with SSI parameters scheduled for 7:30am, 11:30am, and 4:30pm. -From 03/13/25 to 03/31/25, Resident #2's FSBS was documented at 7:30am, 11:30am, and 4:30pm and ranged from 90-346. -There was no entry for Lispro SSI, 0-200= 0 units, 201-250= 2 units, 251-300=6 units, 301-350=8 units, 351-400=10 units scheduled at 7:30am, 11:30am, and 4:30pm. Review of Resident #2's April 2025 eMAR revealed: -There was an entry for FSBS before meals with SSI parameters scheduled for 7:30am, 11:30am, and 4:30pm. -From 04/01/25 to 04/15/25, Resident #2's FSBS was documented at 7:30am, 11:30am, and 4:30pm and ranged from 84-233. -There was no entry for Lispro SSI, 0-200=0 units, 201-250=2 units, 251-300=6 units, 301-350=8 units, 351-400=10 units scheduled at 7:30am, 11:30am, and 4:30pm. Observation of Resident #2's medications on hand revealed Resident #2 did not have Lispro insulin available. Interview with Resident #2 on 04/16/25 at 2:40pm revealed: -The facility staff checked his FSBS three times daily before meals. -He thought he was supposed to receive an insulin injection at meals if his FSBS was elevated. -The facility staff administered his insulin once daily in the morning.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 18 -He thought the staff had parameters to follow to administer his insulin, but he was unsure if the orders were in his records. Interview with a medication aide (MA) on 04/16/25 at 11:10am revealed: -She followed the instructions on the residents' eMARs when she administered medications. -If she had questions about instructions on the eMAR, she asked the Resident Care Coordinator (RCC). -The RCC sent new medication orders to the facility's contracted pharmacy and the pharmacy entered the orders in the eMAR system. -Resident #2 had an order to check his blood sugar three times a day before meals. -She administered Resident #2's Lantus at 8:00am daily. -Resident #2 did not have any other insulin orders on his eMAR. -The only insulin Resident #2 had on the medication cart was Lantus insulin pens. -Resident #2 did not have Lispro insulin on the medication cart. -She first noticed Resident #2's eMAR instructions read to check FSBS with meals with SSI this morning, 04/16/25. -She had not asked the RCC about the instructions for Resident #2's FSBS yet because she had not had a chance to speak with the RCC. Interview with the RCC on 04/16/25 at 11:40am revealed: -When residents received new medication orders, either she or the MAs sent the orders to the facility's contracted pharmacy. -The pharmacy entered the new medication orders into the faciliy's eMAR system. -She was responsible for completing eMAR audits.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 19	D 358		

-She completed eMAR audits when she had time to do them, but did not have a regular schedule to complete the audits.
-MAs should contact her if they had questions or any issues with medication orders on eMARs.
-None of the MAs asked her any questions about Resident #2's FSBS or insulin orders.
-She contacted Resident #2's PCP to clarify his medication orders when he returned to the facility from the rehabilitation facility.
-She was not aware Resident #2's Lispro order was not on his eMAR.
-She usually checked the eMARs after orders were entered at the pharmacy to ensure they were correct, but she did not always get an opportunity to check the orders.
-She did not check Resident #2's new medication orders on the eMAR after she had the orders clarified and sent the orders to the pharmacy.
-MAs should check the residents' new medication orders and should notify her if there were any issues or concerns.
-She was unsure why Resident #2's Lispro was not on his eMAR.
-Resident #2's FL2 and orders were sent to the pharmacy when he returned to the facility from the rehabilitation facility, so the pharmacy should have Resident #2's Lispro order.

Interview with the Administrator on 04/16/25 at 12:10pm revealed:
-When residents received new medication orders, the RCC or MAs sent the order to the facility's contracted pharmacy.
-The pharmacy entered new medication orders into the faciliy's eMAR system.
-Once the pharmacy entered the medication orders, the eMAR system gave the facility a prompt to approve the new medication orders.
-The RCC or MAs could approve new medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 20	D 358		

orders in the eMAR system.
-The RCC usually checked the medication orders to ensure the orders were correct on the eMARs after the pharmacy entered the orders.
-MAs should also check to ensure new medication orders were correct on the eMARs.
-If MAs had questions about medication orders or instructions on the eMARs, they should contact her or the RCC.
-MAs could also contact the pharmacy for any questions about medication orders on the eMARs.
-MAs should follow the instructions on the eMARs when administering medication to residents.
-She was unsure why Resident #2's Lispro order was not on the eMARs.
-She was unsure why the pharmacy entered the FSBS order, but did not enter the corresponding SSI insulin order on Resident #2's eMAR.
-The facility's contracted pharmacy must have overlooked the order on Resident #2's FL2.
-It was important for Resident #2 to receive his medication as ordered to ensure his blood sugar was regulated and did not become too high.

Interview with a pharmacist at the facility's contracted pharmacy on 04/16/25 at 9:27am revealed:
-The pharmacy dispensed 2 Lantus insulin pens for Resident #2 on 03/12/25 and 2 Lantus insulin pens on 04/11/25.
-The pharmacy had not dispensed Lispro insulin for Resident #2.
-The only insulin dispensed for Resident #2 was Lantus insulin.
-The pharmacy had an order for Resident #2 for FSBS before meals with SSI parameters dated 03/12/25.
-She was unsure if the pharmacy had an order for Lispro for Resident #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 21 -She was unsure if the pharmacy had Resident #2's FL2 dated 03/06/25. -The pharmacy's Quality Assurance Manager would need to verify what medication orders the pharmacy had on file for Resident #2. Review of Resident #2's home health agency notes revealed: -On 03/14/25, the home health nurse performed a dressing change to a wound on Resident #3's sacral area (The sacral area is located at the lower base of the spine, above the buttocks). -Resident #2's wound was documented as a stage 3 pressure ulcer (Stage 3 pressure ulcers are wounds that have progressed through the first 2 layers of the skin and into the fatty tissue). -There was documentation of wound care performed by a home health nurse on 03/18/25, 03/20/25, 03/26/25, 03/28/25, 03/31/25, and 04/04/25. Review of Resident #2's consultation report dated 04/14/25 revealed Resident #2 was treated at a local wound clinic for a stage 4 pressure ulcer (Stage 4 pressure ulcers are wounds that have progressed through the first 2 layers of the skin, through the fatty tissue, and into deeper tissues including muscles, ligaments, and tendons). Attempted second interview with a pharmacist at the facility's contracted pharmacy on 04/16/25 at 3:45pm and 4:51pm was unsuccessful. Attempted interview with the Quality Assurance Manager at the facility's contracted pharmacy on 04/16/25 at 3:34pm was unsuccessful. Attempted interview with Resident #2's PCP on 04/16/25 at 2:34pm was unsuccessful.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 22 The facility failed to ensure Resident #2's Lispro insulin was administered as ordered. Resident #2's medication order for Lispro was not entered on the resident's electronic medication administration record (eMAR). Resident #2's blood sugar was greater than 200 a total of 26 times from 03/13/25 to 04/15/25, which would have required Lispro insulin to be administered per sliding scale order, resulting in Resident #2 missing 26 doses of Lispro from 03/13/25 to 04/15/25. Resident #2's elevated blood sugar levels placed Resident #2 at risk for complications related to his diagnoses of diabetes mellitus and a stage 4 pressure ulcer. This facility's failure to administer Resident #2's insulin as ordered was detrimental to the resident's health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/16/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 31, 2025.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 366	Continued From page 23	D 366		

medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observation, interviews, and record reviews, the facility failed to ensure 1 of 5 residents (#5) where observed taking their medication.

The findings are:

Review of the facility's medication administration policy (not dated) revealed staff will provide documentation on the MAR after observing the residents taking the medications and before administration to another resident.

Review of Resident #5's current FL-2 dated 02/11/25 revealed:
-Diagnoses included Schizophrenia, bipolar disorder, dementia, and gastroesophageal reflux disease.
-There was an order for calcium vitamin D3 600/400 twice a day (used to treat low calcium and vitamin D levels).
-The resident's current level of care was Special Care Unit (SCU).

Review of Resident #5's Resident Register revealed, an admission date 05/17/01.

Observation of Resident #5's room on 04/15/25 at 9:35am revealed one light oval shaped pink pill sitting on top of multiple tissues in the top dresser drawer.

Interview with Resident #5 on 4/15/25 at 9:50am revealed:
-The pill was her calcium pill that she took daily.
-She could not recall why the pill was lying in her dresser drawer, for how long it had been lying in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 366	Continued From page 24	D 366		

her dresser, or how it got inside her dresser.

Interview with a personal care aide (PCA) on 4/15/25 at 11:15am revealed:
-She was not aware of any medication in Resident #5's dresser drawer.
-No residents on the SCU hall could self-administer their medications.

Interview with a medication aide (MA) on 4/16/25 at 10:40am revealed:
-She was not aware of any medication in Resident #5's dresser drawer.
-There were several residents on the SCU who wandered and would go into other residents' rooms.

Interview with a Resident Care Coordinator (RCC) on 4/15/25 at 11:35am revealed:
-She was not aware of any medication in Resident #5's dresser drawer.
-She was unsure of what the pill was or what it was used for.
-The medication was not supposed to be in a resident room.
-The medication was not safe to be left in a resident room because another resident could find it and take it.
-The MA was responsible for watching a resident take their medication before leaving the room.

Interview with Administrator on 4/15/25 at 3:50am revealed:
-She was not aware of any medication in Resident #5's dresser drawer.
-She expected her MAs to pass mediations as ordered, watch the resident take the medication, and dispose of any medication that a resident refused.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 366	Continued From page 25 Attempted telephone interview the Resident #5's primary care provider (PCP) on 04/16/25 at 2:35pm was unsuccessful.	D 366		