STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

(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 a complaint investigation August 27, 2025 through August 28, 2025. The complaint investigation was initiated by the Johnston County Department of Social Services on August 15, 2025.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 1 of 1 resident (#3) with a Licensed Health Professional Support (LHPS) evaluation recommended to notify the resident's primary care provider (PCP) about overgrown and discolored toenails and a referral for physical therapy evaluation. The findings are: 1. Review of Resident #3's current FL2 dated 06/10/25 revealed stroke, Parkinson's disease, chronic obstructive pulmonary disease, and coronary artery disease. Review of Resident #3's Resident Register revealed the resident's admission date was 08/30/24. a. Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated	D 273		

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04/28/25 revealed:
-The skin assessment check list showed Resident #3's right great toenail was lifting.
-Recommendation was to notify Resident #3's primary care provider (PCP) about her right great toenail.

Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 07/29/25 revealed:
-The skin assessment check list showed Resident #3's toenails were overgrowing onto other toes and left second toenail was discolored.
-Recommendation was to notify Resident #3's PCP about her toenails overgrowing onto other toes and left second toenail was discolored.

Review of the facility contracted podiatrist appointment list revealed Resident #3 was not seen by the podiatrist on 07/07/25 or 07/08/25.

Observation of Resident #3's right foot on 08/27/25 at 9:00am revealed:
-The great toenail on the right foot was discolored, thick, and splitting.
-The other four toe toenails on the right foot were long and discolored.

Interview with Resident #3 on 08/27/25 at 9:00am revealed:
-Her right foot hurt but she had not told medication aide (MA) recently.
-She could not remember the last time she had mentioned her foot was hurting.
-She had not seen a podiatrist since she had been living in the facility.

Interview with personal care aide (PCA) on 08/27/25 at 9:35am and 11:40am revealed:
-She provided showers to Resident #3 and made

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observations of her feet.
-She noticed Resident #3's toenails were long and needed to be trimmed two months ago.
-The shower sheet had a box to check yes if the feet needed attention and no if it did not and she did not check either box to clarify that Resident #3's feet needed attention.
-She reported Resident's #3 toenails needing to be trimmed to the Resident Care Coordinator (RCC) in June 2025.
-The RCC said she would get Resident #3 an appointment with the podiatrist.
-Resident #3 was not on the podiatry list at the next appointment schedule in July 2025.
-She reported to the RCC when saw Resident #3 was not on the list to see the podiatrist.

Interview with MA on 08/27/25 at 9:20am revealed:
-She was not aware Resident #3 was having issues with her right foot or that her toenails needed filing.
-She reviewed the shower sheets to assess if the PCA mentioned toenails needed trimming.
-The PCAs would verbally let her know that the toenails needed to be trimmed.

Interview with the Clinical Nurse Consultant (CNC) on 08/27/25 at 12:00pm revealed:
-She was responsible for completing the facility's LHPS evaluations.
-On 04/28/25, she assessed Resident #3 and made recommendations on the LHPS.
-Resident #3 right great toenail was lifting, with no bleeding or discharge.
-She sent an email to the RCC regarding the great toe.
-She recommended that Resident #3's toenail be assessed and toenails be cut.
-She was not aware Resident #3's toenails

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received attention.
-She provided recommendations to the RCC who followed up with the primary care provider (PCP).
-She did not recall if the PCP was notified regarding the recommendations from 04/28/25.
-On 08/14/25, she assessed Resident #3 and made recommendations on the LHPS.
-She provided recommendations to the RCC who followed up with the primary care provider PCP.
-She did not recall if the PCP was notified regarding the recommendations from 08/14/25.

Interview with the Administrator on 08/27/25 at 12:30pm revealed:
-She was not aware Resident #3 was having pain in her foot or that she needed to be seen by a podiatrist.
-The RCC was responsible to follow up with the LHPS nurse recommendations and notifying the PCP.
-On 06/07/25, the contracted podiatry came to the facility, but she was not aware Resident #3 was not on the podiatry list.
-She was not aware the PCP had not been notified.

Interview with the primary care provider (PCP) on 08/27/25 at 5:30pm revealed:
-She did not recall Resident #3 complaining about foot pain.
-The RCC did not notify her regarding the LHPS assessment on 04/28/25 and 08/14/25.
-Her expectation was the staff to communicate with her any issues or recommendations that Resident #3 may have.
-Ingrown toenails could cause pain, infection and could make the toenail more susceptible to toenail fungus.

b. Review of Resident #3's neurology provider

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referral form dated 07/29/25 revealed there was an order for physical therapy (PT) for strengthening.

Interview with Resident #3 on 08/27/25 at 9:00am revealed she did not recall needing physical therapy.

Interview with the Administrator on 08/27/25 at 12:00pm revealed:
-She was not aware Resident #3 had a PT order.
-The Resident Care Coordinator (RCC) was responsible for ensuring health care orders were implemented.
-The RCC was no longer with the facility.
-The RCC was responsible for auditing the charts for ensuring orders were implemented.

Interview with the Operations Directors (OD) on 08/27/25 at 11:54am revealed:
-An order was written for Resident #3 for PT on 07/29/25 and was not implemented.
-She was not aware that the PT order was in Resident #3's chart.
-The RCC was responsible to review all follow-up and health care orders.
-The RCC was responsible for auditing twice per week and making sure all orders in the chart were implemented.
-The Administrator was responsible for making sure audits were completed and accurate.

Interview with Resident #3's primary care provider (PCP) on 08/27/25 at 5:30pm revealed:
-She was not aware of Resident #3's PT order.
-The facility was working on communication between her and outside providers to better understand what Resident #3 needed.

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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 CONTINUING TYPE B VIOLATION Based on these findings, the Previously Unabated Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents (#9) observed during the medication pass including errors with a medication for pain, a medication for constipation, and a potassium supplement; and for 1 of 5 residents (#4) sampled for record review related to an error with a medication used to treat high cholesterol. The findings are: 1. The medication error rate was 12% as evidenced by the observation of 3 errors out of 25 opportunities during the 8:00am medication pass on 08/28/25. a. Review of Resident #9's current FL-2 dated 10/22/24 revealed diagnoses included essential	D 358		

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hypertension, dorsalgia (back pain), decreased white blood cell count, and major depressive disorder.

Review of Resident #9's physician's orders dated 07/17/25 revealed an order for Miralax powder give 17 grams mixed in 4 ounces of water once daily (Miralax is a medication used to treat constipation).

Observation of the 8:00am medication pass on 08/28/25 revealed:
-The medication aide (MA) prepared 17 grams of Miralax powder mixed in water in an 8 oz plastic cup.
-The MA handed the cup to Resident #9 at 7:49am and did not tell the resident that the Miralax was mixed in the water.
-Resident #9 drank less than half of the water with Miralax and handed the cup back to the MA.
-The MA disposed of the remainder of water with Miralax in the cup without encouraging the resident to drink more of it.

Review of Resident #9's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax give 17 grams in 4 oz of water daily scheduled for 8:00am.
-Miralax was documented as administered from 08/01/25 to 08/28/25.

Observation of Resident #9's medications on hand on 08/28/25 at 7:45am revealed there was a bottle of Miralax labeled give 17 grams mixed in 4 ounces of water once daily.

Interview with Resident #9 on 08/28/25 at 12:21pm revealed:
-She typically drank about half of the water she

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received with her morning medication pass and rarely drank all the water offered with her medications.
-She did not know that Miralax was mixed in with her water for morning medication pass.
-She denied current problems with constipation.

Interview with the MA on 08/28/25 at 12:30pm revealed:
-Resident #9 usually drank all water with Miralax offered to her but did not this morning.
-She did not encourage Resident #9 to drink all the water with Miralax, and she did not tell Resident #9 that Miralax was mixed in the water she was given this morning because she forgot to do this.

Interview with the Lead Supervisor on 08/28/25 at 1:15pm revealed:
-Resident #9 should have been told if Miralax was mixed into water and the resident should have been encouraged to drink all of the water.
-If a resident refused to take all of the Miralax, that should be documented appropriately on the eMAR as an exception.

Interview with the Administrator on 08/28/25 at 1:30pm revealed:
-The MAs should administer all medications as ordered.
-When a resident did not take all of a medication mixed in water such as Miralax, the MA should have told the resident that the medication was mixed in the water and encouraged the resident to drink all of the water.

Telephone interview with Resident #9's primary care provider (PCP) on 08/28/25 at 5:50pm revealed:
-Resident #9 could have experienced issues with

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constipation due to not receiving all of her ordered Miralax dose.
-Resident #9 had a higher risk for constipation because she received long-term narcotics for chronic pain.
-Resident #9 should have been encouraged to take all Miralax at each dose as ordered.

b. Review of Resident #9's physician's orders dated 07/17/25 revealed an order for Potassium Chloride 20 mEq 1 tablet daily with or after meals with a full glass of water (Potassium Chloride is used to treat low levels of potassium and taking it with or after eating helps with absorption and reduces the risk of stomach irritation).

Observation of the 8:00am medication pass on 08/28/25 revealed:
-The medication aide (MA) prepared and administered potassium chloride 20 mEq to Resident #9 at 7:49am.
-The resident drank about half the water, and the MA did not encourage her to drink all of the water.
-The resident reported at that time that she had not eaten breakfast that morning and never ate breakfast.
-Resident #9's Potassium Chloride was not administered with or after a meal of with a full glass of water as ordered.

Review of Resident #9's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Potassium Chloride 20 mEq 1 tablet once daily with or after meals with a full glass of water scheduled at 8:00am.
-Potassium Chloride was documented as administered daily at 8:00am from 08/01/25 to 08/28/25.

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D 358	Continued From page 9 Observation of Resident #9's medications on hand on 08/28/25 at 7:45am revealed there was a card for Potassium Chloride labeled as Potassium Chloride 20 mEq 1 tablet once daily with or after meals with a full glass of water. Interview with Resident #9 on 08/28/25 at 12:21pm revealed: -She never ate breakfast and did not recall experiencing side effects from morning medications taken on an empty stomach. -She took medications this morning, 08/28/25, on an empty stomach. -The facility staff knew she never ate breakfast. Interview with the MA on 08/28/25 at 12:30pm revealed: -Resident #9 never ate breakfast but had snacks in her room to eat as desired. -Medications ordered to be administered with or after meals should be given while the resident was eating or after they ate a meal. -She administered Resident #9's Potassium Chloride today, 08/28/25, without knowing if she had anything to eat. Interview with the Lead Supervisor on 08/28/25 at 1:15pm revealed: -A medication ordered to be given with or after meals should be given with or sooner after a resident ate a meal. -If a medication ordered with or after meals was due at a time the resident typically did not eat, the provider should have been contacted and asked if the time of administration could be changed. Interview with the Administrator on 08/28/25 at 1:30pm revealed Resident #9's primary care provider (PCP) should have been notified that the resident never ate breakfast so the time of	D 358		

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Potassium Chloride administration could be changed.

Telephone interview with Resident #9's PCP on 08/28/25 at 5:50pm revealed:
-Potassium Chloride was ordered to be administered with or after meals to reduce likelihood of side effects such as gastrointestinal upset and to aid in absorption.
-Resident #9 had gastrointestinal problems such as heartburn and indigestion in the past.

c. Review of Resident #9's physician's orders dated 07/17/25 revealed there was an order for Acetaminophen 325mg take 2 tablets (650mg) twice daily scheduled at 8:00am and 8:00pm (Acetaminophen is used to treat mild pain).

Observation of the 8:00am medication pass on 08/28/25 revealed:
-Resident #9's morning medications were packaged in a multi-dose pack (MDP)
-There was only one Acetaminophen 325mg tablet in the MDP.
-There was a small torn area in the bottom of the MDP large enough for a tablet to pass through.
-The medication aide (MA) prepared and administered one Acetaminophen 325mg tablet to Resident #9 at 7:49am instead of 2 tablets as ordered.

Review of Resident #9's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Acetaminophen 325mg take 2 tablets (650mg) by mouth twice daily scheduled at 8:00am and 8:00pm.
-Acetaminophen 325mg 2 tablets was documented as administered at 8:00am and 8:00pm from 08/01/25 to the 8:00am dose on

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D 358	Continued From page 11 08/28/25. Observation of Resident #9's medications on hand on 08/28/25 at 7:45am revealed the MDP card included a label for Acetaminophen 325mg take 2 tablets (650mg) twice daily. Interview with Resident #9 on 08/28/25 at 12:21pm revealed: -She had pain from two back fractures and from a right hip fracture that occurred 8 years ago. -She was not experiencing more pain than usual. Interview with the MA on 08/28/25 at 12:30pm revealed: -She did not notice that there was only 1 Acetaminophen 325mg tablet in the MDP with the 8:00am medications this morning. -She did not compare the tablets available in the MDP to the eMAR to ensure the right medication was in the MDP. Interview with the Lead Supervisor on 08/28/25 at 1:15pm revealed medications in the MDP should have been matched to the eMAR at each medication pass to ensure the right medications were available and administered to the residents. Interview with the Administrator on 08/28/25 at 1:30pm revealed MAs should have compared the medications in the MDP to the eMAR and ensured that the right medications were present to administer. Telephone interview with Resident #9's primary care provider (PCP) on 08/28/25 at 5:50pm revealed she had no concerns with Resident #9 missing one Tylenol from the MDP this morning, 08/28/25, due to the other pain medications she received every day.	D 358		

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D 358	Continued From page 12 2. Review of Resident #4's current FL-2 dated 10/28/24 revealed: -Diagnoses included dementia, coronary artery disease, stroke, hypertension, and prostate cancer. -There was an order for Atorvastatin 40mg once a day. (Atorvastatin is used to lower cholesterol and reduce the risk of heart attack and stroke.) Review of Resident #4's physician's order dated 08/01/25 revealed an order to increase Atorvastatin to 80mg 1 tablet every evening. Review of Resident #4's August 2025 electronic medication administration record (eMAR) dated 08/01/25 - 08/27/25 revealed: -There was an entry for Atorvastatin 40mg 1 tablet once daily scheduled at 8:00pm. -Atorvastatin 40mg was documented as administered from 08/01/25 - 08/26/25 except on 4 occasions with the resident unavailable on one occasion and the resident refused on 3 occasions. -There was no entry for Atorvastatin 80mg 1 tablet every evening as ordered on 08/01/25. Observation of Resident #4's medications on hand on 08/28/25 at 3:41pm revealed: -The resident's medications were packaged in multi-dose packs (MDPs). -The weekly cycle fill MDP with a print date of 08/20/25 included one Atorvastatin 40mg tablet in the bedtime MDP. -The instructions were for Atorvastatin 40mg take 1 tablet once daily. -There was no supply of Atorvastatin 80mg tablets available for administration. Interview with a medication aide (MA) on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051060	A. BUILDING: _____ B. WING _____	R-C 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

(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 13 08/28/25 at 3:41pm revealed: -She was not aware Resident #4's Atorvastatin dose had been increased to 80mg. -The resident received Atorvastatin 40mg as indicated on the eMAR. Telephone interview with an Order Entry Technician with the facility's contracted pharmacy on 08/28/25 at 6:48pm revealed: -The pharmacy usually entered orders into the eMAR system when orders were received. -The pharmacy did not receive Resident #4's order for Atorvastatin 80mg 1 tablet every evening. -Since the order was never received, Atorvastatin 80mg was not on the eMAR and no Atorvastatin 80mg tablets had been dispensed. Interview with the Administrator on 08/28/25 at 6:30pm revealed: -She was not aware Resident #4 had an order for Atorvastatin 80mg that was not implemented. -The MAs usually sent resident's hospital discharge paperwork to the pharmacy so orders could be entered into the eMAR system and implemented. Telephone interview with Resident #4's primary care provider (PCP) on 08/28/25 at 5:15pm revealed: -Resident #4 had history of having a stroke. -She remembered reading hospital discharge paperwork and saw that the resident's Atorvastatin dose was increased by a hospital provider. -She had no immediate concerns about the resident's Atorvastatin dose not being increased because the resident was taking other medications for his heart health.	D 358		

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D 358	Continued From page 14 Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable.	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 reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#1) for an inhaler used to treat chronic obstructive pulmonary	D 367		

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D 367	Continued From page 15 disease. The findings are: Review of Resident #1's current FL-2 dated 06/19/25 revealed: -Diagnoses included Alzheimer's disease, dementia without behaviors, chronic obstructive pulmonary disease, and hypertension. -There was an order for Advair 250-50mcg inhaler, inhale 1 puff twice daily. (Advair is a combination inhaler used to treat chronic obstructive pulmonary disease.) Observation of Resident #1's medications on hand on 08/28/25 at 4:08pm revealed: -There was one Advair 250-50mcg inhaler dispensed on 08/12/25 with 60 doses (a 30-day supply). -The instructions were to inhale 1 puff twice daily. -There was a handwritten open date of 08/13/25 written on the box above the prescription label. -The dose counter on the Advair inhaler indicated there was 60 of 60 doses remaining; none had been used. Review of Resident #1's August 2025 eMAR dated 08/01/25 - 08/27/25 revealed: -There was an entry for Advair 250-50mcg inhaler, inhale 1 puff twice daily scheduled at 8:00am and 8:00pm. -Advair inhaler was documented as administered on 39 of 53 occasions from 08/01/25 - 08/27/25 (8:00am). -Advair inhaler was documented as refused on 14 occasions from 08/01/25 - 08/27/25 (8:00am). -There were 19 doses of Advair documented as administered from 08/13/25 after the inhaler was initialed as first opened but no doses had been used from the inhaler.	D 367		

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D 367	Continued From page 16 -Documentation for the administration of Advair was not accurate. Interview with a medication aide (MA) on 08/28/25 at 4:08pm revealed: -Resident #1 sometimes refused the Advair inhaler or was too confused to use it. -She could not explain why Advair was documented as administered when no doses from the available Advair inhaler had been used. -The Advair inhaler should have been documented as refused since it had not been administered. Interview with the Special Care Coordinator (SCC) on 08/28/25 at 6:20pm revealed: -The MAs should not document a medication was administered if it was refused. -The MAs should notify her if a resident refused a medication and she would contact the provider. -She and the Resident Care Coordinator (RCC) were responsible for doing at least 2 medication cart audits weekly to make sure medications were being administered and matched documentation on the eMAR. Interview with the Administrator on 08/28/25 at 6:22pm revealed: -The MAs should document accurately on the eMAR. -If a medication was not administered, the MA should not document it as administered. -The SCC and RCC were responsible for medication cart audits twice a week, including comparing the medications to the eMARs to make sure the eMARs were accurate.	D 367		