STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068037	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LIVNING ASSISTED LIVING	624 JONES FERRY ROAD CARRBORO, NC 27510

(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 completed and annual and complaint investigation survey on October 14-15, 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 health care referral and follow-up for 1 of 5 sampled residents (#1) related to clarification of medication orders following a physician's appointment. The findings are: Review of Resident #1's FL2 dated 05/06/25 revealed diagnoses included impaired cognition, multiple sclerosis (MS), and optic atrophy. Interview with Resident #1 on 09/24/25 at 2:40pm revealed: -He went to his neurologist's office in February of this year. -He was instructed to stop taking his teriflunomide (a medication used to decrease relapse rates in MS) by his neurologist. -He did not return to the facility with any paperwork from the appointment. -He recalled telling someone at the facility he was supposed to stop taking the teriflunomide but did not remember who he told. -He remembered he was taking the teriflunomide pill until sometime the week prior.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068037	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LIVNING ASSISTED LIVING	624 JONES FERRY ROAD CARRBORO, NC 27510

(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 273	Continued From page 1	D 273		

-He made his own appointment using an electronic application.
-He stated that he did not take any medications at that time.
-He felt "okay" at that time.

Review of Resident #1's neurology provider's order dated 09/18/25 revealed an order to stop administration of teriflunomide immediately.

Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed:
-There was an entry for teriflunomide 14mg daily with a scheduled administration time of 8:00am.
-Teriflunomide 14mg was documented as administered daily from 08/01/25 to 08/31/25.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for teriflunomide 14mg daily with a scheduled administration time of 8:00am
-Teriflunomide 14mg was documented as administered daily on 09/01/25, 09/06/25 to 09/09/25, and 09/11/25 to 09/18/25.
-Teriflunomide 14mg was documented as not administered on 09/02/25 to 09/05/25, and 09/10/25 due to the medication being out of stock.

Telephone interview with Resident #1's primary care provider (PCP) on 10/15/25 at 11:30am revealed:
-The neurology provider was not sending after visit summaries to the facility after a resident had an appointment.
-The facility never received the order to discontinue the teriflunomide.
-Resident #1 was "no worse for the wear" after taking the teriflunomide for the extended period of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068037	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LIVNING ASSISTED LIVING	624 JONES FERRY ROAD CARRBORO, NC 27510

(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 273	Continued From page 2 time. Telephone interview with Resident #1's neurology provider on 10/15/25 at 2:30pm revealed: -Resident #1 saw his neurologist on 02/14/25 and was instructed to discontinue teriflunomide. -The neurologist's office placed the discontinue instructions in Resident #1's electronic health application. -The neurologist's office did not send a copy of the discontinuation order to the facility. -No one from the facility followed up to let the neurologist's office know they did not receive the order. -The teriflunomide was discontinued in February 2025 because Resident #1's liver enzymes were elevated. -When Resident #1 went to see the neurologist on 09/18/25, it was discovered he was still receiving the teriflunomide and an order was sent to the facility to discontinue it immediately. -At the appointment on 09/18/25, the neurologist rechecked Resident #1's liver enzymes and they went down leading him to think Resident #1 was not receiving the teriflunomide daily. Interview with a representative from the facility's contracted pharmacy on 10/08/25 at 11:24am revealed an order to discontinue the teriflunomide was received on 09/18/25. Interview with the Resident Care Coordinator (RCC) on 09/24/25 at 2:00pm revealed: -Resident #1 went to a neurology appointment on 09/18/25 and it was discovered he was still taking teriflunomide which should have been discontinued in February 2025. -It was the RCC's responsibility to follow up with the physician's office after appointments if no documentation was returned or if there was	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068037	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LIVNING ASSISTED LIVING	624 JONES FERRY ROAD CARRBORO, NC 27510

(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 273	Continued From page 3 clarification of orders needed. -She was not employed at the facility in February so she was not sure why no one called the neurologist's office after Resident #1 returned from his appointment. -If a resident returned from an appointment without any paperwork, the RCC at that time should have called the physician's office to find out if there were any new orders. Interview with Administrator on 09/26/25 at 3:30pm revealed: -The facility never received an order to discontinue the teriflunomide from the neurologist's office for Resident #1. -The RCC was responsible for following up with outside providers for documentation of appointment summaries and to check for new orders. -After Resident #1 went to the neurologist on 09/18/25, the teriflunomide was discontinued.	D 273		
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: Based on observation, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068037	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LIVNING ASSISTED LIVING	624 JONES FERRY ROAD CARRBORO, NC 27510

(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 4	D 358		

residents (#2) including a medicated shampoo.

The findings are:

Review of Resident #2's current FL2 dated 07/10/25 revealed diagnoses of burn of the 3rd degree on left thigh, muscle weakness, unsteadiness on feet, cognitive communication deficit, need for assistance with personal care, type 2 diabetes mellitus, morbid obesity and hyperlipidemia.

Review of Resident #2's current FL2 dated 07/10/25 revealed an order for ketoconazole cream 2% (used to treat fungal infections) apply to affected facial areas twice daily.

Review of Resident #2's September 2025 and October 2025 from 10/01/25 to 10/14/25 electronic medication administration records (eMAR) revealed there was no entry for ketoconazole cream 2% apply to affected facial areas twice daily.

Observation of Resident #2's medications on hand on 10/14/25 at 2:00pm revealed there was no Ketoconazole available for administration for Resident #2.

Interview with Resident #2 on 10/14/25 at 9:10am revealed:
-Resident #2 asked for his 'face cream' and stated he never received it.
-Resident #2 stated that he did not understand why he could not receive it.

Telephone interview with a representative from the facility's contracted pharmacy on 10/04/25 at 12:53pm revealed:
-Someone needed to enter the FL2 in its entirety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068037	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LIVNING ASSISTED LIVING	624 JONES FERRY ROAD CARRBORO, NC 27510

(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 5 into the system for the medications to be listed for administration on the eMAR, and the order for ketoconazole cream had not been entered. -The pharmacy did not dispense ketoconazole for Resident #2. -No one at the facility called and requested the medication to be dispensed. Interview with Administrator on 10/15/25 at 2:55pm revealed: -The Resident Care Coordinator (RCC) should audit the resident's orders and compare them to the eMARs to make sure all the medication was available for administration. -After Resident #2's FL2 was faxed to the pharmacy, the RCC or the medication aide (MA) should have ensured all Resident #2's medication arrived at the facility. -Resident #2 had requested ketoconazole for his scalp. -Resident #2 was being seen by home health, and their treatments had made his skin and scalp much better at that time.	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 medication. Pre-charting is prohibited.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068037	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LIVNING ASSISTED LIVING	624 JONES FERRY ROAD CARRBORO, NC 27510

(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 6 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed a resident take their medications that were left on the dining room table. The findings are: Observation of the dining room on 10/15/25 at 7:51am revealed: -A MA placed a cup of pills next to a resident and walked out of the dining room. -The resident was sitting alone at the table. -There were two pills in the small white cup. Interview with a resident on 10/15/25 at 7:53am revealed: -The MA left her two pills on the dining room table for her to take. -Some MAs watched her take all of her medications, and other MAs did not. Interview with a personal care aide (PCA) on 10/15/25 at 8:39am revealed she had not seen pills left in the dining room or a residents' room to be taken later. Interview with a second PCA on 10/15/25 at 8:51am revealed: -She had not seen medication left on the tables in the dining room. -She had not seen medications left in any of the residents' rooms. Interview with a MA on 10/15/25 at 10:26am revealed: -She watched all residents take their medication before she left the resident.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068037	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEFUL LIVNING ASSISTED LIVING	624 JONES FERRY ROAD CARRBORO, NC 27510

(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 7 -She did not leave medication for a resident to take at a later time. -She did not realize that she walked away prior to the resident taking her medication. Interview with a second MA on 10/15/25 at 10:09am revealed: -She watched residents take their medications. -She did not leave medications in the dining room or in a residents' room to take at a later time. -She did not leave medications with residents, because another resident could have taken the medications. Interview with the Resident Care Coordinator (RCC) on 10/15/25 at 2:11pm revealed: -She had not noticed any medications left in a resident's room or the dining room for residents to take. -The MA was responsible for watching the residents take their medications before the MA walked away. Interview with the Administrator on 10/15/25 at 2:55pm revealed: -Medications should not be left on the dining room table for a resident to take. -The MA should watch residents take their medication during the administration of the medications. -The MA should not leave medications; another resident may walk by and pick them up and take the medications. -She expected the MAs to watch the residents take their medications.	D 366		