STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043015	A. BUILDING: _____ B. WING _____	R 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

(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 on 08/27/25 and 08/28/25.	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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation is abated. Non-compliance continues. Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 1 of 5 sampled residents related to notifying the provider of a medication used to treat seizures that was not available for administration (#4). The findings are: Review of Resident #4's current FL-2 dated 10/16/25 revealed: -Diagnoses included a history of traumatic brain injury and epilepsy. -He was ambulatory and intermittently disoriented. Review of Resident #4's physician's order dated 07/09/25 revealed Valtoco nasal spray 10mg, 1 spray to be administered intranasal as needed at the onset of a seizure and may repeat in 4 hours if needed. (Valtoco (diazepam nasal spray) is a medication used to seizure activity.)	D 273		

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D 273	Continued From page 1 Review of Resident #4's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Valtoco 10mg, 1 spray to be administered intranasal as needed at the onset of a seizure and may repeat in 4 hours if needed. -There was no documentation Valtoco 10mg was administered. Review of Resident #4's August 2025 eMAR revealed: -There was an entry for Valtoco 10mg, 1 spray to be administered as needed at the onset of a seizure and may repeat in 4 hours if needed. -There was no documentation Valtoco 10mg was administered. Observation of medications on hand for Resident #4 on 08/27/25 at 3:07pm revealed there was no Valtoco nasal spray available for administration. Interview with the medication aide (MA) on 08/27/25 at 3:10pm revealed: -Resident #4's Valtoco nasal spray never arrived from the pharmacy. -She kept requesting the medication through the computerized eMAR system but it never arrives. -She did inform Resident #4's primary care provider (PCP) and the Resident Care Director (RCD) in July that the medication was ordered but had not arrived. Interview with Resident #4 on 08/28/25 at 8:48am revealed he did not remember when he last had a seizure but thought it was 1-2 months prior. Telephone interview with the pharmacist for the facility's contracted pharmacy on 08/28/25 at	D 273		

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D 273	Continued From page 2 9:23am revealed: -Valtoco was a medication used to treat seizures when a seizure occurred but was not used to prevent a seizure. -The co-pay for Resident #4 was almost $500.00 because it was a newer medication. -Resident #4's neurologist did not want to discontinue the medication and the family did not want to pay the co-pay for the medication as of 07/31/25. -There was no communication with the facility, Resident #4's family member or nephrologist after 07/31/25. -Valtoco had not been dispensed to the facility in July 2025 but was scheduled to be dispensed on 08/27/25. Interview with Resident #4's primary care provider (PCP) on 08/28/25 at 8:59am revealed: -A medication aide (MA) made her aware that a neurologist ordered a nasal spray for seizure but the medication had not arrived to the facility. -The medication not being available had not been discussed with her in August 2025 but she would have deferred the discussion to the prescribing neurologist office. -There were alternative medications that could be used to treat a seizure but they did not work as fast as the nasal spray. Telephone interview with the medical assistant for Resident #4's neurologist on 08/28/25 at 9:40am revealed there was no documentation of communication from the facility regarding Resident #4's Valtoco and they were not aware Resident #4 did not have the medication to treat a seizure. Telephone interview with the Clinical Coordinator for Resident #4's neurologist on 08/28/25 at	D 273		

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D 273	Continued From page 3	D 273		

9:57am revealed:
-There had been no communication from the facility regarding Resident #4's Valtoco.
-The facility should have reached out to them regarding the high co-pay for the medications; The facility should have called or faxed a communication with the concern.
-They were not aware the co-pay was $400-$500 and would not expect a resident or their family to pay such a high cost.

Interview with the Resident Care Director (RCD) on 08/28/25 at 10:08am revealed:
-He was made aware Resident #4's Valtoco was not in the facility sometime mid-July when it did not arrive after it was ordered.
-He did not follow-up because the pharmacy was "handling it".
-He was not aware the medication was still not in the facility as of 08/27/25.
-He had not reached out to Resident #4's neurologist office regarding the medication because the pharmacy was handling it and he did not think his calling them would make a difference.
-The previous RCD trained him that the pharmacy handled the communications with the providers regarding medications and communications with the family regarding payment of the medications.

Interview with the Administrator on 08/28/25 at 10:29am revealed:
-The facility did not reach out to the neurologist to let them know Resident #4's medication was not available.
-He expected the pharmacy to reach out to the neurologist when the family did not want to pay to have the medication filled.

Attempted telephone interview with Resident #4's

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D 273	Continued From page 4 Guardian on 08/27/25 at 3:57pm was unsuccessful. Attempted telephone interview with Resident #4's Power of Attorney (POA) on 08/28/25 at 9:35am was unsuccessful.	D 273		