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 _____	05/30/2025

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 an annual survey on 05/28/25 - 05/30/25 with an exit conference via telephone on 05/30/25.	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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for routine and acute health care needs for 3 of 5 sampled residents (#1, #2, #5) related to notifying the primary care provider of a resident having behaviors and exiting the facility without staff's knowledge who was found outside and had fallen (#2), a referral to podiatry for a diabetic resident (#1), and cardiology follow-up visits for a resident with a cardiac pacemaker and a history of chest pain (#5). The findings are: 1. Review of Resident #2's current FL-2 dated 06/07/24 revealed: -Diagnoses included type II diabetes, hypertension, hyperlipidemia, gastroesophageal reflux disease (GERD), history of transient ischemic attack (TIA), depression, irritable bowel syndrome, and cerebral infarction without residual. -Resident #2 was ambulatory without an assistive device.	D 273		

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 _____	05/30/2025

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

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D 273	Continued From page 1 -Resident #2's orientation was intermittent. Review of Resident #2's care plan dated 06/27/24 revealed: -Resident #2 required supervision with eating. -Resident #2 required limited assistance with toileting. Review of Resident #2's incident report dated 02/02/25 revealed: -The date and time of the incident was 02/02/25 at 10:27pm. -The type of incident was listed a "fall of unknown origin". -The location of the incident was other: outside on community grounds. -The signs of injuries were documented as a cut on head and EMT (emergency medical technicians) said a possible broken arm. -Resident #2 was transported to a local hospital. -It was documented the primary care provider (PCP) was notified on 02/03/25 at 8:00am. -It was documented the resident's Responsible Person was notified on 02/02/25 at 10:28pm. -It was documented that the previous Resident Care Director (RCD) was the person who completed the report on 02/03/25 at 8:45pm. Review of Resident #2's progress note dated 01/28/25 at 7:51pm revealed: -Resident #2 was seen walking out of her room wearing only one sock. -Resident #2 stated she was going home, and staff could not keep her at the facility. -Resident #2 was escorted back to her room and informed staff she had millions of dollars' worth of diamonds and asked staff to retrieve the jewelry. -Resident #2 became agitated and accused the staff of taking her jewelry.	D 273		

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	HAL043015	A. BUILDING: _____ B. WING _____	05/30/2025

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

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D 273	Continued From page 2 Review of Resident #2's progress note dated 01/28/25 at 8:43pm revealed: -Resident #2 tried to leave the facility for a second time that evening. -Staff was able to redirect Resident #2 before she could get to the door. Review of Resident #2's progress note dated 01/29/25 at 1:32am revealed: -Resident #2 kept coming out of her room stating she was going home. -Staff redirected Resident #2 back to her room each time. Review of Resident #2's progress note dated 02/02/25 at 10:37pm revealed: -Resident #2 had been directed twice for trying to leave the facility stating that she was going home. -The medication aide (MA) was able to get Resident #2 back in her room and settled in bed. -Resident #2 was not found in her room after the final rounds. -Resident #2 was found outside on the facility grounds. -Resident #2 had fallen and possibly had a broken arm, head lacerations and face injuries. Interview with Resident #2 on 05/29/25 at 6:50pm revealed she remembered falling and breaking her arm but did not remember when and where the fall occurred. Interview with a personal care aide (PCA) on 05/29/25 at 1:10pm revealed: -Resident #2 would not always remember where her room was. -Resident #2 was easily redirected. -Resident #2 had come to the nurses' station on 05/27/25 and the resident did not know where she was.	D 273		

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 _____	05/30/2025

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OAK HILL LIVING CENTER	9767 NC 210-N ANGIER, NC 27501

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D 273	Continued From page 3 Interview with a second PCA on 05/29/25 at 6:02pm revealed: -Resident #2 had come to her on the evening of 02/02/25 asking where her room was, the PCA escorted Resident #2 back to her room. -Resident #2 had come out of her room for a second time on 02/02/25 asking for snacks; the PCA provided Resident #2 with snacks and escorted her back to her room. -During the rounds, between 9:00pm and 10:00pm, the PCA checked on Resident #2 and found that she was not in her room. -The assigned MA was notified immediately. -Resident #2 was found outside in the side circle driveway nearest the 100 hall. -Resident #2 had a visible head injury and she was bleeding from her head and knee. -Resident #2 was confused and crying, saying she wanted to go home. -Resident #2 complained that her arm was hurting. -She did not remember how long Resident #2 had not been in her room when she was found outside. -Resident #2 had not been placed on increased supervision. -Resident #2 was checked on every 2 hours. Interview with a MA on 05/29/25 at 10:46pm revealed: -Resident #2 would at times walk towards the front door saying she was leaving and going to her car. -Resident #2 did not have a car. -She noticed Resident #2 had gone outside last week (date not provided) and sat thinking a family member was coming to take her to lunch. -She went outside and asked Resident #2 to come back inside for lunch.	D 273		

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 _____	05/30/2025

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

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D 273	Continued From page 4	D 273		

-She called Resident #2's family member and had the family member talk with Resident #2 and tell the resident that the family member could not take the resident out for lunch because the family member had to work.
-Resident #2 would wander around almost daily around 3:00pm.
-She had increased Resident #2's supervision by completing one hour checks.
-She had not documented the increased one hour checks.

Interview with a second MA on 05/29/25 at 5:18pm revealed:
-She had learned Resident #2 was not in her room on 02/02/25 by a PCA around 8:30pm.
-She immediately gathered all of the staff, and a search begin.
-She found Resident #2 outside lying on the ground in the side circle driveway nearest the 100 hall.
-Resident #2 had fallen and had a head injury and facial bruises.
-Resident #2 was crying and said her arm was hurting.
-When the EMTs arrived, they assessed Resident #2 for a possible broken arm due to the fall.
-She completed an incident report on 02/02/25 and placed the report in the previous RCD's folder.
-She did not remember Resident #2's diagnoses but Resident #2 was always crying and seemed depressed.
-Resident #2 wandered a lot since she had been admitted to the facility and always stated she was going home.
-She did not know why Resident #2 wanted to leave the evening of 02/02/25.
-Resident #2 had displayed wandering behaviors since she had been admitted to the facility.

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 _____	05/30/2025

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 273	Continued From page 5	D 273		

-She would report the behaviors to the previous RCD and would document each time she observed Resident #2 trying to leave the facility or saying she was going to leave the facility.

Telephone interview with Resident #2's power of attorney (POA) on 05/29/25 at 2:43pm revealed:
-She received a call from the facility staff on 02/02/25 around 10:30pm that Resident #2 tried to leave the facility and had a bad fall and was found outside at the end of the first circle driveway.
-She had been informed the alarm had not been set.
-Resident #2 had suffered from a head injury, broken arm and facial bruises.
-The weather on the night of 02/02/25 was in the low to mid 40s.
-Resident #2 had a diagnosis of dementia and the facility was aware of the diagnosis.
-Staff would inform her of Resident #2's wandering behavior and said they were able to redirect her but had not provided any additional interventions.
-She had inquired with the Administrator when the door alarms were to be set at night but was never provided a clear answer.
-Resident #2 was discharged from the emergency room on 02/03/25 to a rehabilitation center.
-Resident #2 was at the rehabilitation center from 02/03/25 to 03/19/25.
-The RCD had informed her that staff would keep a closer watch on Resident #2.

Telephone interview with Resident #2's family member on 05/29/25 at 2:43pm revealed:
-The family member had been informed by the Administrator that Resident #2 had been outside for 30 to 45 minutes before she was found

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 _____	05/30/2025

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 273	Continued From page 6	D 273		

outside.
-Resident #2 had tried to leave the facility a couple days before she was found outside on the evening of 02/02/25.

Telephone interview with Resident #2's previous PCP's office on 05/30/25 at 11:35am revealed:
-Resident #2 was last seen on 10/30/24 for a routine visit.
-There was no documentation of the PCP being informed of Resident #2's elopement and wandering issues.
-There was no documentation of the PCP being informed of the 02/02/25 incident.

Telephone interview with Resident #2's current PCP on 05/30/25 at 1:30pm revealed:
-Resident #2 was a new patient and was last seen on 05/13/25.
-Resident #2 had a diagnosis of dementia.
-She was not made aware of the 02/02/25 incident where Resident #2 tried to leave the facility and had fallen outside.
-She had not been informed of Resident #2's previous elopement and wandering issues.
-She had not been made aware Resident #2 had received rehabilitation services.
-Resident #2 had been at her baseline and she had not made any observations of wandering behaviors.
-Had she been made aware of the 02/02/25 incident or the previous wandering behaviors she would have increased supervision checks for Resident #2.

Interview with the Resident Care Coordinator (RCC) on 05/29/25 at 12:54am revealed:
-Resident #2 was identified as a wanderer.
-The resident's PCP should be notified if the resident had a fall resulting in injuries, elopement

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 _____	05/30/2025

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 273	Continued From page 7	D 273		

or change in behavior or health.
-She or the RCD were responsible for informing the residents' PCP of falls with injuries and changes in the residents' condition.

Telephone interview with the RCD on 05/30/25 at 1:50pm revealed:
-He was hired as the RCD on 02/11/25.
-He did not have any information about Resident #2's 02/02/25 incident.
-He had not known of any previous elopement and wandering behavior issues with Resident #2.
-He had met with Resident #2 in the rehabilitation facility to completed a reassessment on 03/08/25.
-He met with the POA on 03/08/25 and informed her staff would keep an eye on Resident #2 by checking her room more often and ensuring Resident #2 went to the dining room for her meals.
-There were no physician progress notes in Resident #2's chart.
-The increased supervision checks were not documented in Resident #2's chart.
-Staff were to inform him or the RCC of any changes in residents' behaviors.
-He, the RCC, or the Administrator were responsible for contacting the residents' PCP regarding injuries.

Interview with the Administrator on 05/29/25 at 3:43pm revealed:
-Elopement was defined as an undocumented leave from the facility.
-The staff were to contact the residents' PCP, POA and authorities if needed.
-Residents' PCPs were contacted when a resident had a fall and needed medical treatment and for changes in behavior.
-The PCP was notified via fax.
-Resident #2's incident occurred on 02/02/25

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 _____	05/30/2025

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 273	Continued From page 8	D 273		

around 10:30pm.
-Resident #2's current PCP had not recommended increased supervision.
-The staff were to report any changes in a resident's condition to him or the RCD.
-The previous RCD reported Resident's #2's 02/02/025 incident.
-He thought Resident #2's PCP was informed of the 02/02/25 incident.

2. Review of Resident #1's current FL-2 dated 03/10/25 revealed:
-Diagnoses included type 2 diabetes mellitus, hypertension, and hyperlipidemia.
-She was ambulatory with no devices.

Observation of Resident #1's feet on 05/28/25 at 9:39am revealed:
-Her left foot first toe had a thickened yellow toenail that extended approximately ½ inch over the tip of her toe.
-Her left foot 2nd and 3rd toenails were thick and yellow and extended approximately ¼ inch of the tips of the toes.
-Her left foot 4th toe had a thickened yellow toenail that curved over the tip of the toe approximately ½ inch and pressed into the pad of the 4th toe.
-Her left foot 5th toe had a thickened yellow toenail that curved over the tip of the toe approximately ½ inch and inward into the side of the 4th toe.
-There was an increased pink color noted at the base of the nailbed on the 4th and 5th toes.
-Her right foot first toe had a thickened yellow toenail that extended approximately ¼ inch - ½ inch over the tip of her toe and curved inward towards her 2nd toe.
-Her right foot 2nd toenail was thick and yellow and curved inward onto the pad of the 2nd toe.

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 _____	05/30/2025

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 273	Continued From page 9	D 273		

-Her right foot 3rd toenail was thick and yellow and extended approximately ½ inch - ¾ inch over of the tip of the toe and curved inward towards and over onto the top of the 2nd toe.
-Her right foot 4th toe had a thickened yellow toenail that curved over the tip of the toe approximately 1 inch and pressed in between the pads of the 3rd and 4th toes.
-Her right foot 5th toe had a thickened yellow toenail that curved up and over the tip of the toe approximately ¾ inch onto the pad of the toe.
-There was an increased pink color noted at the base of the nailbed on the 5th toe.

Review of Resident #1's Resident Register revealed an admission date of 03/27/25.

Interview with Resident #1 on 05/28/25 at 9:32am revealed:
-Her toenails were long and needed trimming.
-Her toenails had not been trimmed since she was admitted to the facility.
-She was diabetic and wanted her toenails to be trimmed.

Second interview with Resident #1 on 05/29/25 at 1:00pm revealed:
-She could walk without the use of any devices.
-She wore her black slip on walking shoes.
-She did not complain of skin breakdown and understood the importance of foot care for a diabetic.
-She had spoken with facility staff about her toenails needing to be cut but she could not recall who she spoke with or when she spoke with them.
-She had seen the primary care provider (PCP) right after she was admitted to the facility but did not remember the exact date.
-The PCP had ordered some lotion for her feet

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 _____	05/30/2025

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 273	Continued From page 10	D 273		

and a podiatry appointment for her due to the condition of her toenails and her being a diabetic.
-The medication aides (MAs) put the lotion on her feet every night.
-She had not seen a podiatrist since she was admitted to the facility but would definitely like to see one to get her toenails trimmed.
-She was able to provide all her own care except she could not trim her toenails due to the extreme thickness of the nails.

Interview with a personal care aide (PCA) on 05/29/25 at 8:40am revealed:
-She had never provided nail care to Resident #1.
-Resident #1 was independent as far as she knew.
-The PCAs were not allowed to do nail care to diabetic residents.

Interview with a MA on 05/29/25 at 11:05am revealed:
-She did not know if Resident #1 saw a podiatrist.
-The Resident Care Director (RCD) would know if Resident #1 saw a podiatrist or was scheduled to see them.
-She did not know anything about Resident #1's toenails.
-The staff were not allowed to cut diabetic residents' toenails.
-Resident #1 had some lotion for her feet but it was administered by the second shift MAs.

Interview with the RCD on 05/29/25 at 10:45am revealed:
-Resident #1 had been seen by the facility's PCP right after she arrived (could not remember the exact date).
-The PCP had written a referral order for Resident #1 see a podiatrist.
-The facility's contracted podiatrist came to the

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 _____	05/30/2025

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 273	Continued From page 11	D 273		

facility to see the residents quarterly.
-Their last visit was in March 2025.
-Resident #1 was placed on the list to see the podiatrist at their next visit which was the first week in June 2025.
-He did not realize the condition of her toenails at the time of the PCP's visit; he just put her on the next appointment list.

Telephone interview with Resident #1's PCP on 05/30/25 at 1:19pm revealed:
-She had seen Resident #1 on 05/08/25 but was not aware of any problems with her toenails.
-Her colleague had seen Resident #1 on 04/09/25 and ordered a podiatry appointment.
-She would be concerned about any skin breakdown, wounds, or infections that may be caused by her toenail condition since Resident #1 was a diabetic.

Telephone interview with the Administrator on 05/30/25 at 2:13pm revealed:
-He was not aware of the condition of Resident #1's toenails other than what he had been told by the RCD (but did not explain what he had been told).
-He was not aware if Resident #1 was able to do her own personal care or not.
-He would expect the staff to notify the RCD if residents needed to be seen by the PCP or podiatrist.

3. Review of Resident #5's current FL-2 dated 10/02/24 revealed:
-Diagnoses included vascular dementia with anxiety, cerebrovascular atherosclerosis, coronary artery disease, sick sinus syndrome, aortic stenosis status post valve replacement, essential hypertension, type 2 diabetes mellitus, hyperlipidemia, and gastroesophageal reflux

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 _____	05/30/2025

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 273	Continued From page 12	D 273		

disease.
-The resident was documented as constantly disoriented.

Review of Resident #5's Resident Register revealed the resident's date of admission to the facility was 10/14/24.

Review of Resident #5's current assessment and care plan dated 10/15/24 revealed:
-The resident's diagnoses (in addition to the diagnoses on the FL-2 dated 10/02/24) included chronic ischemic heart disease.
-The resident was documented as sometimes disoriented, forgetful, and needed reminders.

Review of Resident #5's facility progress note dated 10/28/24 at 7:03am revealed:
-The resident said he was having severe chest pain, and it felt like heavy pressure.
-The resident was administered a Nitroglycerin (medication used to treat chest pain) tablet that helped a little.
-Staff called 911 immediately and the resident was transported to the hospital.

Review of Resident #5's hospital emergency room (ER) after visit summary (AVS) dated 10/28/24 revealed:
-The resident was seen at the ER for chest pain.
-The resident was diagnosed with nonspecific chest pain.
-The test results showed the resident was most likely not having a heart attack.
-It was impossible to be 100% certain it was not the resident's heart.
-The resident was to follow-up with his primary care provider (PCP) as soon as possible regarding the ER visit.
-The resident was to return to the ER if he

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 _____	05/30/2025

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 273	Continued From page 13	D 273		

experienced any further chest pain/pressure/tightness, difficulty breathing, sudden sweating, or other symptoms that concerned him.
-The PCP documented "reviewed" and initialed the top right corner of the AVS form and dated it 10/30/24.

Review of Resident #5's facility charting note dated 11/07/24 at 11:40pm revealed:
-At 11:05pm, the resident was complaining of chest pain and stated he was having a heart attack.
-Emergency Medical Services (EMS) was called and the resident's vital signs were taken.
-The resident's blood pressure was 138/76, pulse was 60, and oxygen level was 92%.
-The resident was transported to the hospital.

Review of Resident #5's hospital ER AVS form dated 11/08/24 revealed:
-The resident was seen at the ER for chest pain.
-The resident was diagnosed with nonspecific chest pain.
-Instructions included follow-up with the PCP and a cardiology provider.
-The PCP documented "reviewed" and initialed the top right corner of the AVS form and dated it 11/13/24.

Review of Resident #5's facility charting note dated 01/10/25 at 6:02pm revealed:
-At dinner, another resident told staff that Resident #5 was not doing good.
-Staff went to see Resident #5 and the resident appeared very pale and appeared unresponsive.
-The resident was pulled in his chair outside of the dining room and into the hallway until EMS arrived.
-The resident held his chest and said to call for

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 _____	05/30/2025

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 273	Continued From page 14	D 273		

help.
-The resident was administered a Nitroglycerin tablet.
-Before EMS arrived, the resident's blood pressure was 89/55.
-When EMS arrived, the resident's blood pressure was 70/55.
-The resident's pulse was 60, respirations were 18, and his oxygen level was 92%.
-The resident was transported to the hospital.

Review of Resident #5's facility charting note dated 01/13/25 at 4:53pm revealed:
-The resident returned to the facility from the hospital via EMS.
-The resident's paperwork was faxed to the pharmacy.

Review of Resident #5's hospital discharge summary dated 01/13/25 revealed:
-The resident was admitted to the hospital on 01/10/25 and discharged on 01/13/25.
-The resident's admission diagnoses included syncope (fainting or temporary loss of consciousness) and acute kidney injury.
-The resident was initially noted to be hypotensive (low blood pressure) and complained of chest pain.
-A pacemaker interrogation (checked the device to ensure it was working properly) was completed and showed the resident was being paced 99% of the time (indicated the heart was primary relying on the device for rhythm regulation).
-The resident had a history of sick sinus syndrome (heart rhythm disorder) status post pacemaker (implanted device that delivers electrical impulses to the heart to regulate the heart rate), aortic valve stenosis (narrowing of the large blood vessel in the heart) status post valve replacement on chronic Warfarin therapy,

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 _____	05/30/2025

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 273	Continued From page 15	D 273		

hypertension, diabetes, and vascular dementia.
-At the time of discharge, the resident's heart had normal rate and regular rhythm.
-There were instructions to follow-up with the cardiologist within one week.
-The resident was to follow-up with the cardiology provider to review medication and make any necessary changes.
-The resident's family member stated the resident could be taken to his cardiologist within one week of hospital discharge.
-There were instructions to follow-up with the PCP within one week.

Review of Resident #5's physician visits and charting notes revealed no documentation of Resident #5 being seen by a cardiology provider.

Interview with the Resident Care Director (RCD) on 05/29/25 at 4:30pm revealed:
-He was not working at the facility in January 2025 when Resident #5 was hospitalized and had instructions to see a cardiologist.
-The previous RCD would have been responsible for setting up the appointment or reaching out to the resident's family member.
-He spoke with the resident's family member today, 05/29/25, who was the resident's health care power of attorney (POA).
-The family member did not make a cardiology appointment for the resident.
-There was no documentation regarding the resident's cardiology appointment to his knowledge.
-The family member told the RCD that the resident's pacemaker was monitored via a transmitter device in the resident's room.
-He did not know when the resident's pacemaker was last checked or how often it should be checked.

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 _____	05/30/2025

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

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D 273	Continued From page 16 Telephone interview with a scheduler at Resident #5's cardiology provider's office on 05/30/25 at 10:08am revealed: -Resident #5 had not been seen by the provider in 2025. -The resident had an appointment for a physical in-office device check for his pacemaker on 04/25/25 but it was a "no show, no call" appointment. -That meant the resident did not come to the appointment and no one called to cancel the appointment. -There was no documentation of any appointments being scheduled for any hospital follow-ups in 2025. -The resident had a pacemaker check appointment scheduled for 07/25/25. Telephone interview with the RCD on 05/30/25 at 11:49am revealed: -He was not aware Resident #5 had an appointment scheduled with the cardiology provider on 04/25/25. -He was not aware Resident #5 had an upcoming appointment scheduled with the cardiology provider on 07/25/25. -Neither the 04/25/25 or the 07/25/25 cardiology appointments for Resident #5 were listed on the facility's resident appointment schedule book. Telephone interview with the Administrator on 05/30/25 at 2:14pm revealed: -The RCD and Resident Care Coordinator (RCC) worked in conjunction and were responsible for referrals. -Resident #5's family member knew about the cardiology appointments and chose not to take the resident. -There was no documentation indicating why the	D 273		

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 _____	05/30/2025

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 273	Continued From page 17	D 273		

resident did not follow-up with a cardiology provider.
-There was no documentation regarding the resident's missed cardiology appointment.
-The Administrator, RCD, and RCC reviewed all resident care data quarterly.
-There were weekly meetings with the RCC about resident issues.
-No other system to monitor health care referrals and follow-up was indicated.

Telephone interview with Resident #5's PCP on 05/30/25 at 1:17pm revealed:
-She was transitioning into the role of the facility's contracted PCP in April 2025.
-She was not aware Resident #5 had missed any cardiology appointments or pacemaker checks.
-She thought it was okay to push out the resident's pacemaker check by 1 to 3 months as long as the resident was not having any current symptoms.

Attempted telephone interview with Resident #5's family member on 05/29/25 at 5:45pm was unsuccessful.

Attempted telephone interview with Resident #5's cardiology provider on 05/30/25 at 10:12am was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable.

_____

The facility failed to ensure health care referral and follow-up for 3 of 5 sampled residents. The facility failed to notify Resident #2's previous primary care provider (PCP) of behaviors of confusion and trying to leave the facility and requiring redirection by staff on 01/28/25 and

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 _____	05/30/2025

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 273	Continued From page 18 01/29/25, prior to the resident exiting the facility without staff's knowledge on 02/02/25 and being found later by staff outside lying on the pavement with injuries including a fractured arm and head injuries. The facility also failed to make the resident's current PCP aware of the resident's past behavior of trying to leave the facility and requiring redirection. The facility failed to coordinate timely podiatry care for Resident #1, who was diabetic, and had long, thickened, yellow toenails, including some toenails that were so long they curved over the top of the toes and pressed into the pads of the toes, putting the resident at risk for skin breakdown, wounds, and infections. The facility failed to coordinate follow-up visits with a cardiology provider after a hospitalization for syncope (fainting) and for pacemaker checks for Resident #5 who had multiple diagnoses related to the condition of his heart and had two past visits to the emergency room for chest pain. The failure of the facility to provide health care coordination and follow-up was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/30/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 14, 2025.	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	D 358		

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 _____	05/30/2025

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 358	Continued From page 19	D 358		

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 observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents (#5) sampled for record review including multiple missed doses of a blood thinner medication used to treat and prevent blood clots.

The findings are:

Review of the facility's undated Medication Policies and Procedures revealed:
-If not automatically refilled by the pharmacy, refills must be ordered.
-Reorder medication 5 days in advance of need to assure adequate supply on hand.

Review of Resident #5's current FL-2 dated 10/02/24 revealed:
-Diagnoses included vascular dementia with anxiety, cerebrovascular atherosclerosis, coronary artery disease, sick sinus syndrome, aortic stenosis status post valve replacement, essential hypertension, type 2 diabetes mellitus, hyperlipidemia, and gastroesophageal reflux disease.
-The resident was documented as constantly disoriented.
-There was an order for Warfarin 5mg 1 ½ tablets once a day. (Warfarin is a blood thinner used to treat and prevent blood clots.)

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 _____	05/30/2025

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 358	Continued From page 20	D 358		

Review of Resident #5's clarification of hospital discharge orders dated 01/15/25 revealed the Warfarin dose was changed to 5mg 1 tablet daily.

Review Resident #5's lab report dated 03/24/25 revealed:
-The resident's INR lab was collected on 03/24/25. [International Normalized Ratio (INR) is a lab value used to monitor Warfarin therapy. The target INR range is generally recommended to be 2.0 - 3.0 for most clinical situations.]
-The resident's INR was 2.35 (within therapeutic range).

Review of Resident #5's physician's order dated 04/10/25 revealed:
-There were no new medication changes.
-There was an order to recheck INR next week.

Review Resident #5's lab report dated 04/17/25 revealed:
-The resident's INR lab was collected on 04/17/25.
-The resident's INR was 1.2 (below therapeutic range).

Review of Resident #5's physician's order dated 04/17/25 revealed:
-There was an order for Warfarin 5mg 1 tablet daily.
-There was an order for Warfarin 1mg 1 tablet on Mondays, Wednesdays, and Fridays (in addition to 5mg to equal 6mg).

Review of Resident #5's April 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Warfarin 5mg 1 tablet once a day scheduled at 8:30pm.
-Warfarin 5mg was documented as administered

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 _____	05/30/2025

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 358	Continued From page 21	D 358		

daily from 04/01/25 - 04/12/25 and 04/16/25.
-Warfarin 5mg was documented as not being administered daily from 04/13/25 - 04/15/25 due to medication not on cart.
-This entry for Warfarin 5mg 1 tablet daily was documented as being discontinued on 04/17/25.
-There was a second entry for Warfarin 5mg 1 tablet once a day scheduled at 8:30pm with a start date of 04/17/25.
-Warfarin 5mg 1 tablet daily was documented as administered from 04/17/25 - 04/21/25 and 04/24/25 - 04/30/25.
-Warfarin 5mg 1 tablet daily was documented as not being administered on 04/22/25 and 04/23/25 due to medication not on cart.
-There was an entry for Warfarin 1mg 1 tablet daily on Monday, Wednesday, and Friday, take with the 5mg tablet to equal 6mg total.
-Warfarin 1mg was scheduled to be administered at 8:30pm on Mondays, Wednesdays, and Fridays.
-Warfarin 1mg was documented as not being administered on Friday, 04/18/25; Monday, 04/21/25, and Wednesday, 04/23/25 due medication not on cart, medication on order.
-Warfarin 1mg was documented as administered on Friday, 04/25/25, Monday, 04/28/25, and Wednesday, 04/30/25.
-The resident did not receive 5 doses of Warfarin 5mg and 3 doses of Warfarin 1mg as ordered in April 2025.

Review Resident #5's lab report dated 05/05/25 revealed:
-The resident's INR lab was collected on 05/05/25.
-The resident's INR was 1.7 (below therapeutic range).

Review of Resident #5's verbal order dated

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 _____	05/30/2025

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 358	Continued From page 22 05/07/25 revealed: -There was an order for Warfarin 5mg 1 tablet daily. -There was an order for Warfarin to 1mg tablet on Mondays, Wednesdays, Fridays, Saturdays, and Sundays (in addition to the 5mg tablet daily). Review Resident #5's lab report dated 05/21/25 revealed: -The resident's INR lab was collected on 05/21/25. -The resident's INR was 2.8 (within therapeutic range). Review of Resident #5's physician's orders dated 05/22/25 revealed: -The resident's recent INR was 2.8 (within therapeutic range). -There was an order to continue the current Warfarin regimen and repeat INR in 2 weeks. Review of Resident #5's May 2025 eMAR dated 05/01/25 - 05/29/25 revealed: -There was an entry for Warfarin 5mg 1 tablet once a day scheduled at 8:30pm. -Warfarin 5mg was documented as administered daily from 05/01/25 - 05/20/25. -This entry for Warfarin 5mg 1 tablet daily was documented as being discontinued on 05/21/25. -There was a second entry for Warfarin 5mg 1 tablet once a day scheduled at 8:30pm with a start date of 05/21/25. -Warfarin 5mg 1 tablet daily was documented as administered from 05/21/25 - 05/28/25. -There was an entry for Warfarin 1mg 1 tablet daily on Monday, Wednesday, and Friday, take with the 5mg tablet to equal 6mg total. -Warfarin 1mg was scheduled to be administered at 8:30pm on Mondays, Wednesdays, and Fridays.	D 358		

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 _____	05/30/2025

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 358	Continued From page 23	D 358		

-Warfarin 1mg was documented as administered on Friday, 05/02/25 and Monday, 05/05/25.
-This entry for Warfarin 1mg was documented as being discontinued on 05/07/25.
-There was a second entry for Warfarin 1mg 1 tablet daily on Monday, Wednesday, Friday, Saturday, and Sunday, take with the 5mg tablet to equal 6mg total.
-Warfarin 1mg was scheduled to be administered at 8:30pm on Mondays, Wednesdays, Fridays, Saturdays, and Sundays.
-Warfarin 1mg was not documented as being administered on 05/10/25 due to medication not on cart.
-The resident received Warfarin 5mg on 05/10/25 instead of Warfarin 6mg as ordered.

Review of Resident #5's medications on hand on 05/29/25 at 11:02am revealed:
-There was a supply of Warfarin 5mg tablets dispensed on 05/21/25 with instructions to take 1 tablet once a day.
-There were 7 of 14 Warfarin 5mg tablets remaining.
-There was a supply of Warfarin 1mg tablets dispensed on 05/21/25 with instructions to take 1 tablet daily on Monday, Wednesday, Friday, Saturday, and Sunday (take with the 5mg tablet to equal 6mg total).
-There were 5 of 10 tablets remaining.
-Both supplies of Warfarin had a round green sticker in the upper left corner of the bubble card.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/29/25 at 5:19pm revealed:
-The pharmacy provided monthly cycle fills for most scheduled medications with some exceptions.
-Warfarin was not included in monthly cycle fills

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 _____	05/30/2025

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 358	Continued From page 24	D 358		

because of potential for frequent dose changes due to INR levels.
-Non-cycle fill medications, including Warfarin, had a round green sticker on the bubble card to let facility staff know it was not a cycle fill medication and had to be reordered.
-The facility staff would have to reorder fills for Warfarin since it was a non-cycle medication.
-The pharmacy dispensed and delivered 5 Warfarin 5mg tablets on 04/07/25.
-Warfarin was not reordered again by facility staff until 04/15/25 at 8:28pm when staff clicked the reorder button on the eMAR system.
-There was no refill request by the facility prior to 04/15/25 at 8:28pm.
-The pharmacy dispensed and delivered 7 Warfarin 5mg tablets on 04/16/25.
-The resident's INR was checked on 04/17/25 and 3 Warfarin 1mg tablets were dispensed and delivered to the facility on 04/17/25 due to an order change.
-Warfarin 1mg would have been available for administration at the facility on 04/18/25, 04/21/25, and 04/23/25.
-There were 10 Warfarin 1mg tablets dispensed and delivered to the facility on 05/07/25 so it would have been available for administration on 05/10/25.

Review of Resident #5's pharmacy dispensing records dated 12/01/24 - 05/29/25 revealed:
-There were 14 Warfarin 5mg tablets (14-day supply) dispensed on 03/24/25.
-There were 5 Warfarin 5mg tablets (5-day supply) dispensed on 04/07/25.
-There were 7 Warfarin 5mg tablets (7-day supply) dispensed on 04/16/25.
-There were 3 Warfarin 1mg tablets (3 doses = 1 week supply) dispensed on 04/17/25.
-There were 10 Warfarin 1mg tablets (10 doses =

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 _____	05/30/2025

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 358	Continued From page 25	D 358		

2 weeks supply) dispensed on 05/07/25.
-There were 14 Warfarin 5mg tablets (14-day supply) dispensed on 05/07/25.
-There were 10 Warfarin 1mg tablets (10 doses = 2 weeks supply) dispensed on 05/21/25.
-There were 14 Warfarin 5mg tablets (14-day supply) dispensed on 05/21/25.

Interview with a medication aide (MA) on 05/29/25 at 6:00pm revealed:
-She did not recall why Resident #5 ran out of Warfarin in April 2025 and May 2025.
-The MAs usually reordered medications.
-The Resident Care Coordinator (RCC) or Resident Care Director (RCD) could also reorder medications if they saw that the MAs had not ordered it.
-Second shift MAs did not usually contact providers if a resident ran out of a medication because it was usually after business hours on second shift.

Interview with the RCC on 05/29/25 at 5:53pm revealed:
-She worked as a MA at times but not very often to fill in when needed.
-She remembered Resident #5's Warfarin not being in the medication cart in April 2025, so she documented the medication was not on the cart.
-The MAs were responsible for ordering medications when the supply got to the blue colored strip on the bubble card.
-She was not aware of a back-up pharmacy used by the facility.
-She or the MAs would notify the RCD if a medication was not received by the pharmacy and the RCD would notify the provider.
-She did not remember if she notified the RCD about the resident's Warfarin not being on the medication cart.

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	HAL043015	A. BUILDING: _____ B. WING _____	05/30/2025

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 358	Continued From page 26 Interview with the RCD on 05/29/25 at 6:12pm revealed: -The facility's contracted pharmacy delivered medications to the facility every day. -If medications were ordered in the morning, they could usually get them delivered the same day. -He reviewed random eMARs weekly but not all eMARs weekly. -He was not aware Resident #5 had missed any doses of Warfarin in April 2025 or May 2025. -The MAs were responsible for reordering medications when the supply got to the blue strip on the bubble card or a 5-day supply. -He did not recall if anyone had reported Resident #5's Warfarin was not on the medication cart. -There were a lot of times when a MA reported medications were unavailable, but the MAs have overlooked medications that were in the medication cart. Interview with the Administrator on 05/29/25 at 6:55pm revealed: -He was unaware Resident #5 had missed doses of Warfarin in April 2025 and May 2025. -The facility got new medication carts around that time in April 2025 -He wondered if that may have contributed to the MAs not being able to locate the Warfarin in the new medication carts. Telephone interview with Resident #5's primary care provider (PCP) on 05/30/25 at 1:17pm revealed: -She was transitioning into the role of the facility's contracted PCP in April 2025. -She was not aware Resident #5 had missed any doses of Warfarin. -Missed doses of Warfarin could cause low INR levels, which could cause blood clots that could	D 358		

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D 358	Continued From page 27 lead to heart attack or stroke. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable.	D 358		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 4 medication carts in the hallways (100 hall, 400 hall) were locked when not under the direct physical supervision of staff in charge of medication administration. The findings are: Review of the facility's Pharmaceutical Policies and Procedures dated 01/01/20 revealed all prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. 1. Observation of the 400 hall on 05/28/25 between 2:27pm - 2:37pm revealed:	D 378		

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D 378	Continued From page 28 -At 2:27pm, there were two medications carts parked in the hallway between resident rooms 401 and 403. -There was no staff, including no medication aides (MAs,) observed in the 400 hallway or in sight of the medication carts. -The medication cart on the right, near room 403 was unlocked, except the controlled substance drawer was locked. -All other medications on the cart were unlocked and accessible to residents. -At 2:30pm, there was a housekeeper in the hallway of the 400 hall, cleaning the floor. -At 2:32pm, the resident residing in room 401 opened the door, came out of the room into the 400 hallway and looked at the medication carts parked in the hallway beside her room. -The resident then walked further into the hallway and looked toward the 300 hall, then walked back toward her room door, touched a chair in the hall to the left of her room door, then went back in her room and closed the door at 2:33pm. -At 2:36pm, the MA assigned to the 300 hall and 400 hall medication carts came out of the staff lounge near the dining room on another hallway. -The MA stopped to get incontinent supplies for a resident in a storage room across from the staff lounge. -At 2:37pm, surveyor asked the MA to come to the medication carts parked in the hallway of the 400 hall. Interview with the MA assigned to the 300 hall and 400 hall medication carts on 05/28/25 at 2:37pm revealed: -She was last at the medication carts in the hallway of the 400 hall at 2:30pm. -The medication carts should have been locked -She knew that she had locked both medication carts before she left the carts unattended.	D 378		

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D 378	Continued From page 29	D 378		

-Both medication carts should have been locked.
-She was not sure who unlocked the medication cart.
-She thought the Resident Care Coordinator (RCC) and the Resident Care Director (RCD) had keys to the medication carts.

Interview with the RCD on 05/28/25 at 2:55pm revealed:
-The facility got new medication carts about 5 to 6 weeks ago.
-There was a medication cart for each of the halls (100 hall, 200 hall, 300 hall, 400 hall).
-There was a different set of keys for each medication cart.
-The MAs only had keys to the carts they were assigned to during their shift.
-The RCC did not have keys to the new medication carts.
-He had keys to the medication carts.
-He had not unlocked the medication cart in the hallway of the 400 hall today, 05/28/25.

Refer to interview with the RCD on 05/28/25 at 2:55pm

Refer to interview with the Administrator on 05/28/25 at 3:06pm.

Refer to a second interview with the Administrator on 05/29/25 at 1:00pm.

2. Observation of the 100 hall on 05/29/25 from 8:20am - 8:22am revealed:
-At 8:20am, a medication aide (MA) was standing at the 100 hall medication cart parked about halfway down the 100 hall.
-The MA walked away from the 100 hall medication cart without locking the medication cart.

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D 378	Continued From page 30	D 378		

-The MA walked off the 100 hall and passed the nurses' station to the 200 hall to the medication cart parked about halfway down the 200 hall.
-At 8:22am, surveyor asked the MA to come to the 100 hall medication cart parked in the hallway of the 100 hall.

Interview with the MA assigned to the 100 hall medication cart on 05/29/25 at 8:22am revealed:
-She thought she had locked the 100 hall medication cart when she walked away to administer medications on the 200 hall.
-She did not realize she forgot to lock the 100 hall medication cart.
-She should have locked the 100 hall medication cart before she walked away to go to the 200 hall.

Refer to interview with the Resident Care Director (RCD) on 05/28/25 at 2:55pm

Refer to interview with the Administrator on 05/28/25 at 3:06pm.

Refer to a second interview with the Administrator on 05/29/25 at 1:00pm.

_____

Interview with the RCD on 05/28/25 at 2:55pm revealed:
-The medication carts should be locked at all times if a MA was not at the medication cart.
-If a MA walked away from a medication cart and the medication cart was not in sight, the medication cart should be locked.
-The MAs were responsible for ensuring the medication carts were locked when not in use.

Interview with the Administrator on 05/28/25 at 3:06pm revealed:
-The medication carts should be locked except during medication passes when it was under the

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D 378	Continued From page 31 direct supervision of the MAs. -The MAs were responsible for making sure the medication carts were locked. Interview with the Administrator on 05/29/25 at 1:00pm revealed they reviewed with the MAs today, 05/29/25, that the medication carts should be locked when the MAs were not using the medication carts.	D 378		
D9999	Final Observation Based on a decision from this agency the following action has occurred, the Type A1 Violation in Tag D067, 10A NCAC 13F .0305(h)(4) Physical Environment has been deleted.	D9999		