STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 and the Sampson County Department of Social Services conducted an annual survey on 01/15/20 with an exit conference via telephone on 01/17/20.	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 assure follow up for 2 of 5 sampled residents, Resident #5 ordered to follow up with cardiologist 4 days after an Emergency Department (ED) visit for chest pain and a repeat chest x-ray, and Resident #3 whose physician was not notified of a 10 lb weight gain in 15 days.. The findings are: 1. Review of Resident #5's current FL-2 dated 12/05/19 revealed diagnoses included cerebral infraction, hypertension and myocardial infraction. Review of Resident #5's Resident Register revealed: -An admission date of 12/02/19.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 -Resident #5 had a Health Care Power of Attorney (HPOA). Review of Resident #5's Emergency Room (ER) notes dated 12/04/19-12/05/19 revealed: -Resident #5 was seen in the ER on 12/04/19 with a chief complaint of chest pain and epigastric pain. -Resident #5 had sharp mid-sternal chest pain for 3 hours and epigastric pain. -Resident #5 was in observation overnight in the ER for repeat cardiac laboratory studies. -Resident #5 was discharged back to the facility on 12/05/19 with recommendations for "close follow-up with cardiologist" for a outpatient workup. -Results of Resident #5's chest X-ray revealed an 8mm nodular opacity in the right lateral lower lung. -There was a recommendation for Resident #5 to follow up with her primary care physician for a repeat chest X-ray with nipple markers in a month for further characterization of the area. a. Interview with Resident #5 on 01/16/19 at 9:40am revealed: -She had a history of a "heart attack." -She had chest pain on 12/04/19 and had gone to the ER. -She had not seen her cardiologist since her return from the ER on 12/05/19. -The facility never mentioned a follow-up appointment with the cardiologist. -She had seen the facility nurse practitioner (NP) after she returned from ER visit. Telephone interview on 01/16/19 at 8:20am with Resident #5's family revealed: -Resident #5 had a stroke and was unable to make decisions for herself.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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	D 273		

-Resident #5's HPOA was a pilot who lived out of state and was very hard to get in touch with.
-She was on Resident #5's Resident Register as a back-up person to call for Resident #5's care.
-She was not made aware Resident #5 needed a follow-up cardiologist visit after the ER visit on 12/04/19.
-She would try to contact the HPOA for Resident #5 and ask if he was made aware of the cardiologist appointment.

Telephone interview on 01/16/19 at 8:27am with Resident #5's family revealed the HPOA was not aware Resident #5 needed a follow-up appointment with the cardiologist.

Telephone interview on 01/15/19 at 3:40pm and on 01/16/19 at 3:38pm with the cardiologist's Registered Nurse revealed:
-Resident #5 was being seen by the cardiologist for a history of heart failure.
-Resident #5 was last seen in the office on 09/09/18.
-There was not appointment scheduled in December 2019 or January 2020 after the ER visit on 12/04/19.
-She was not aware Resident #5 was seen in the ER for chest pain on 12/04/19.

Interview on 01/16/20 at 10:00am with Resident #5's Nurse Practitioner (NP) revealed:
-She knew Resident #5 had chest pain on 12/04/19 and was sent to the ER for evaluation.
-She had seen Resident #5 on 12/05/19 for a follow-up visit.
-She had ordered Resident #5 to follow-up with the cardiologist in 4 days per the hospital discharge note.
-She did not know Resident #5 was not seen by the cardiologist after the ER visit on 12/04/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 -She expected the facility staff to follow-her orders for Resident #5 to be seen by the cardiologist. Interview on 01/16/20 at 10:15am with the Resident Care Director (RCD) revealed: -She was responsible for scheduling appointments for the residents in the facility. -She did not know Resident #5 had an order to follow-up with the cardiologist after the ER visit on 12/04/19. -She had overlooked the order for a cardiologist appointment to be made 4 days after the ER visit. Interview on 01/16/19 at 3:30pm with the Administrator revealed: -She knew Resident #5 had gone to the ER on 12/04/19 for chest pain. -She did not know Resident #5 had an order to follow-up with the cardiologist 4 days after she returned from the ER on 12/05/19. -She relied on the RCD to handle all the resident's orders and to schedule all appointments. Attempted telephone call on 01/15/19 at 3:00pm and at 6:10pm with Resident #5's HPOA was unsuccessful. b. Interview with Resident #5 on 01/16/19 at 9:40am revealed: -She had chest pain on 12/04/19 and had gone to the ER. -The ER doctor told her the X-ray showed a "knot on her lung". -She did not have a repeat chest X-ray since her ER visit on 12/04/19. -The facility never mentioned obtaining another chest X-ray. -She had seen the facility nurse practitioner (NP)	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 4 after she returned from ER visit. Attempted telephone call on 01/15/19 at 3:00pm and at 6:10pm with Resident #5's HPOA was unsuccessful. Telephone interview on 01/16/19 at 8:20am with Resident #5's family revealed: -Resident #5 had a stroke and was unable to make decisions for herself. -She was not made aware Resident #5 needed a repeat Chest X-ray after the ER visit on 12/04/19. Telephone interview on 01/15/19 at 3:40pm and on 01/16/19 at 3:38pm with the cardiologist's Registered Nurse revealed: -She was not aware Resident #5 was seen in the ER for chest pain on 12/04/19. -She was did not know Resident #5 was recommended a repeat chest X-ray for an 8mm nodular on the ER visit 12/04/19. -The cardiologist office staff does not treat pulmonary issues but definitely if they had known they would recommended treatment and follow up with a pulmonologist. Interview on 01/16/20 at 10:00am with Resident #5's Nurse Practitioner (NP) revealed: -She knew Resident #5 had chest pain on 12/04/19 and was sent to the ER for evaluation. -She had seen Resident #5 on 12/05/19 for a follow-up visit. -She was not aware the ER radiologist ordered a repeat chest X-ray for characterization of an 8mm nodular on 12/04/19 and the XRay was not obtained.. -The facility staff did not make her aware of the order for a repeat chest X-ray for Resident #5. Interview on 01/16/20 at 10:15am with the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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		

Resident Care Director revealed:
-She was responsible for scheduling appointments for the residents in the facility.
-She did not know Resident #5 had an order for a repeat chest X-ray to be scheduled one month after the ER visit on 12/04/19.
-She had overlooked both orders on the discharge summary dated 12/05/19.

Interview on 01/16/19 at 3:30pm with the Administrator revealed:
-She knew Resident #5 had gone to the ER on 12/04/19 for chest pain.
-She did not know Resident #5 had an order to repeat a follow-up chest X-ray due to finding an 8mm nodular on 12/04/19 ER visit.
-She relied on the RCD to handle all the resident's orders.

2.. Review of Resident #3's current FL2 dated 09/13/19 revealed:
-Diagnoses included congestive heart failure (CHF), atrial fibrillation, hypertension, and diabetes.
-There was an order for Resident #3 to be weighed daily and notify the physician if there were weight changes up or down by 3lbs.

Review of Resident #3's January 2020 electronic medication administration record (eMAR) revealed:
-Resident #3 had a weight gain of 5lbs in eight days from 139.5 lbs to 144.6 lbs.
-There was no documentation on the eMAR progress notes the primary care physician was notified.
-There was an additional 5.1 weight gain the following week, 01/06/20-01/11/20.
-There was no documentation on the eMAR the primary care physician was notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 Interview with the medication aide (MA) on 01/16/20 at 9:50am revealed: -Resident #3 had a physician's order to weigh her every day. -The MAs recorded Resident #3's weight on the eMAR. -If the weight was 3lbs or more from the previous day the MAs were to contact the physician. -None of her weight gain this month was more than 3lbs in 24 hours. -We should have contacted the physician with a 10lb gain in 15 days this month. -She was not reviewing the weight gain for the entire week, just the previous 24 hours. Interview with the Registered nurse (RN) at Resident #3's physician's office on 01/16/20 at 10:45am revealed: -The physician was not available due to illness. -The nurse was aware of Resident #3's order to be weighed daily and notify the physician if there were weight changes up or down by 3 pounds -Resident #3 had a diagnosis of CHF and the physician wanted to monitor her fluid retention. -She would have expected the physician to be notified by the facility staff with a 3lb increase in weight, and definitely with a 10lb increase in weight. Interview with the Resident Care Coordinator on 01/16/20 at 12:10pm revealed: -She knew Resident #3 had weight parameters due to her CHF diagnosis. -The MAs weighed Resident #3 every day and recorded the weight on the eMAR. -She reviewed the eMARS at the end of the month. -She would have expected the MAs to inform her of the weight gain despite physician's orders.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 -The MAs thought the weight gain had to be in 24 hours. -She would clarify the order with the staff. Observation of Resident #3 on 01/16/20 at 1:45pm revealed: -Resident #3 was sitting in her wheelchair in her bedroom. -She was agitated during a skin assessment. -Resident #3's right lower leg was edematous. -There was no significant edema in the left leg. Interview with the Administrator on 01/16/20 at 2:45pm revealed: -The staff has been trained to notify the physician for any resident that has a 5lb increase in weight in one month. -The MAs should have notified the RCC of Resident #3's weight gain and the physician. -The parameters on the daily weights should have been followed.	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 observations, interviews, and record reviews, the facility failed to administer medications 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
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 8	D 358		

residents including a vitamin used to increase the absorption of calcium and magnesium (Resident #3).

The findings are:

1. Review of Resident #3's current FL2 dated 09/13/19 revealed:
-Diagnoses included dementia, atrial fibrillation, hypertension, diabetes and congestive heart failure.
-Medication orders included Vitamin D3 50,000 units once a week.

Review of Resident #3's subsequent physician's order dated 12/13/19 revealed Vitamin D3 50,000 units weekly was changed to Vitamin D3 5,000 units daily.

Review of Resident #3's December 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin D3 5,000 units, one capsule weekly, to be administered at 9:00am.
-There was documentation Resident #3 was administered Vitamin D3 weekly on 12/06/19, 12/13/19, 12/20/19, and 12/27/19.

Review of Resident #3's January 2020 eMAR revealed:
-There was an entry for Vitamin D3 5000 units one cap weekly, to be administered at 9:00am.
-There was documentation Resident #3 was administered Vitamin D3 weekly on 01/03/20 and 01/10/20.
-The next scheduled dosage of Vitamin D3 5000 units on the eMAR was 01/17/20.

Observation of Resident #3's medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 9	D 358		

available for administration on 01/16/20 at 10:02am revealed:
-There was an over the counter bottle of Vitamin D 5000 units with Resident #3's name on the cap.
-The bottle contained 100 caplets and four caplets were missing from the bottle.

Review of Resident #3's Progress note dated 01/09/20 revealed:
-The first shift Supervisor documented Resident #3's Vitamin D3 order had been changed to 5,000 units on 12/13/19.
-The Supervisor notified the pharmacy the order was still on the eMAR as 50,000 units weekly.
-Resident #3 received Vitamin D3 5000 units on 12/20/19, 12/27/19 and 01/02/20.
-The pharmacy staff would correct the entry, changing the dosage from 50,000 units to 5000 units, per the physician's order.

Telephone interview with the facility's contracted pharmacy technician on 01/16/20 at 10:10am revealed:
-When the facility staff received an order, the process was to fax a copy of the order to the pharmacy.
-If it was received within business hours, the pharmacy technician entered the order in the eMAR.
-The staff at the facility, with privileges to approve the order, reviewed the entry and if approved the order would be activated for the MAs to administer the medication.
-The order for Resident #3's Vitamin D 5000 units did not as a daily order because the staff who approved the order at the facility entered the start date as 12/13/20, instead of 12/13/19.
-The approval date of 12/13/20 allowed the computer entry to keep the original order of weekly administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 10 Interview with the Resident Care Coordinator on 01/16/20 at 12:10pm revealed: -The MAs process the orders the residents received from their physicians. -When a resident was seen by a physician, the paperwork with any orders was brought back to the MA on that shift. -She would review any orders, labs or follow up appointments. -She would fax orders to the pharmacy and leave the paperwork for any follow up flagged in the resident's record and placed in the "Hot Box". -The next shift was supposed to follow up with the orders and ensure the medication was available for administration. -She did not approve or review Resident #3's Vitamin D3 order change-it was reviewed and approved by the Supervisor. -She did not know Resident #3 missed 30 doses of Vitamin D3 5000 units. Interview with Resident #3's responsible family member on 01/15/20 at 4:45pm revealed: -She was the responsible family member for Resident #3. -She had requested the physician change the Vitamin D3 50,000 units weekly to 5,000units daily. -She felt Resident #3's mood was being affected. -She provided all of the over the counter medications for Resident #3. -She brought a bottle of the Vitamin D3 5000 units to the facility and gave it to the MA about 3 weeks ago. Interview with Resident #3's primary care physician (PCP) on 01/15/20 at 4:35pm revealed: -She was the PCP for Resident #3. -She had identified a Vitamin D deficiency on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 11 Resident #3's last routine laboratory test. -She did not remember the date of the laboratory test, but it was within the last 6 months. -She prescribed Vitamin D3 50,000 units weekly for Resident #3. -Resident #3's family member thought the dose was too high. -She requested the resident to be started on a lower daily dose of Vitamin D3. -The PCP ordered Vitamin D3 5000 units daily for Resident #3. -Vitamin D3 5000 units daily is a current order for Resident #3. Interview with a MA on 01/16/20 at 7:30am revealed: -She was the third shift Supervisor. -She performed cart audits weekly. -She tried to audit 3 resident's medications each shift. -She printed the physician order summary (POS) and used that to compare to the eMAR and the medications on the cart. -She also counted how many pills were remaining for every medication. -She brought the completed sheet to the RCC. -Resident #3's family member brought in most of her medications. -She brought in a new bottle of Vitamin D3 5000 units a few weeks ago because the order changed. -She did not administer the Vitamin D3 on her shift to Resident #3. -The pharmacy or the MAs could put an order on the eMAR. -To activate an order, the RCC must review and approve the order. -Or if the order was entered on the eMAR on the weekend, or when the RCC was not available, another Supervisor could approve it.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 12 Interview with the Administrator on 01/16/20 at 2:45pm revealed: -When an order was received it should be faxed immediately to the pharmacy. -The order was then flagged in the resident's record and left in the "Hot Box"to be followed up on. -The Hot Box was an area in the medication room where resident records are placed when some follow up action needs to be taken. -The Supervisor should follow up each shift on items flagged in records and placed in the Hot Box. -She expected the RCC to verify all orders. -She did not know Resident #3 was not receiving the correct dosage of Vitamin D.	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	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 367	Continued From page 13 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 electronic Medication Administration Record (eMAR) was accurate for 1 of 5 sampled residents related a daily medication entered on the eMAR as a weekly medication, resulting in the resident missing 30 doses of the prescribed medication. The findings are: Review of Resident #3's current FL2 dated 09/13/19 revealed: -Diagnoses included dementia, atrial fibrillation, hypertension, diabetes and congestive heart failure. -Medication orders included Vitamin D3 50,000 units once a week. Review of Resident #3's subsequent physician's order dated 12/13/19 revealed Vitamin D3 50,000 units weekly was changed to Vitamin D3 5,000 units daily. Review of Resident #3's December 2019 electronic medication administration record (eMAR) revealed:	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 367	Continued From page 14 -There was an entry for Vitamin D3 50,000 units one cap weekly, to be administered at 9:00am. -There was documentation Resident #3 was administered Vitamin D3 weekly on 12/06/19, 12/13/19, 12/20/19, and 12/27/19. Review of Resident #3's January 2020 eMAR revealed: -There was an entry for Vitamin D3 5,000 units one cap weekly, to be administered at 9:00am. -There was documentation Resident #3 was administered Vitamin D3 5,000 units weekly on 01/03/20 and 01/10/20. -The next scheduled entry for Vitamin D3 5,000 units was 01/17/20. Review of Resident #3's Progress note dated 01/09/20 revealed: -The first shift Supervisor documented Resident #3's Vitamin D3 order had been changed to 5,000 units on 12/13/19. -The SIC notified the pharmacy the order was still on the eMAR as 50,000 units weekly. -Resident #3 received Vitamin D3 5,000 units on 12/20/19, 12/27/19 and 01/02/20. -The pharmacy staff would correct the entry, changing the dosage from 50,000 units to 5,000 units. Interview with a MA on 01/16/20 at 7:30am revealed: -She was the third shift SIC/MA. -She performed cart audits weekly. -She tried to audit 3 residents medications each shift. -She printed the physician order summary (POS) and used that to compare to the eMAR and the medications on the cart. -She also counted how many pills were left for every medication.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 367	Continued From page 15	D 367		

-She brings the completed sheet to the RCC.
-The pharmacy staff or the MAs could enter an order on the eMAR.
-For an order to become active the RCC must approve it on the eMAR.
-Or if the order was entered on the eMAR on the weekend or when the RCC was not available, another Supervisor could approve it.

Telephone interview with a representative from the facility's contracted pharmacy technician on 01/16/20 at 10:10am revealed:
-When the facility staff received an order, the process was to fax a copy of the order to the pharmacy.
-If it was received within business hours, the pharmacy technician would enter the order onto the eMAR.
-The staff at the facility with privileges to approve the order would review the order entry.
-If the facility staff approved the order, it would populate on the eMAR and the MA's could administer the medication.
-The new order for Resident #3's Vitamin D 5000 units did not populate as a daily order because the start date was entered as 12/13/20 instead of 12/13/19.

Interview with the Resident Care Coordinator on 01/16/20 at 12:10pm revealed:
-The MAs processed the orders the residents received from their physicians.
-When a resident was seen by a physician, the paperwork with any orders is brought to the MA on that shift.
-She would review any orders, labs or follow up appointments.
-The orders will be faxed to the pharmacy, and the original will be flagged in the resident's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 367	Continued From page 16 -The resident's record will be placed in the "Hot Box". -The next shift was supposed to follow up with the orders and ensure the medication was available for administration. -Then the RCC reviewed and approved the order entry and any new medications. -She did not approve or review the order for Vitamin D3 5000 units-it was reviewed and approved by the Supervisor. -She did not know the entry for Resident #3's Vitamin D3 was incorrect on the eMAR. Interview with the Administrator on 01/16/20 at 2:45pm revealed: -When an order was received it should be faxed immediately to the pharmacy. -The order was then flagged in the resident's record and left in the "Hot Box" to be followed up on. -The Supervisor should follow up each shift on items flagged in records and placed in the Hot Box. -She expected the RCC to verify all orders. -She did not know Resident #3's Vitamin D3 was incorrect on the eMAR.	D 367		