Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey via desk review survey on 08/17/2020 - 08/21/2020, and 08/24/2020 with an exit conference via telephone on 08/24/2020.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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~~ DT, 04/13/2021, " 04/13/2021 Settlement Agreement" Based on virtual observations, interviews, and record reviews, the facility failed to assure referral and follow up for acute and routine health care needs for 1 of 3 sampled residents (#2) related to notifying the primary care provider (PCP) of weight loss. The findings are: Review of Resident #2's current FL-2 dated 07/28/20 revealed: -Diagnoses included urinary retention. -He was intermittently confused. -For his nutrition status, there was a diet order for a mechanical soft diet and gastronomy was checked with "see additional info" written. -There was an order for tube feedings: 1 can of nutritional supplement via bolus feed 5 times per day with 60 milliliter (ml) flush of water before and after feeds. -His weight was 182.6 pounds (lbs.) with a height of 6 feet 2 inches. -There was a physician's signature with the date of 07/28/20.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E!	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 246	Continued From page 1 Review of Resident #2's Resident Register revealed an admission date of 07/28/20. Review of Resident #2's Adult Care Home Personal Care Physician Authorization and Care Plan dated 07/31/20 revealed: -He was ambulatory with aide or device. -Device(s) needed were a wheelchair when tired or caregiver assistance with ambulation. -His nutrition was checked for oral and tube. -The tube (type) was left blank. -His height was 6 feet and 2 inches. -His weight was 182.9 lbs. -He was sometimes disoriented. -He was forgetful and needed reminders. -He required supervision with eating, toileting, ambulation/locomotion, bathing, dressing, grooming personal hygiene, and transferring. -The assessor certification was signed and dated by the Administrator with the included titles of Registered Nurse (RN) and Bachelor of Science Nursing (BSN) on 07/31/20. -The physician authorization was signed by Resident #2's primary care provider (PCP) and dated 07/31/20. Review of Resident #2's July 2020 electronic medication administration record (eMAR) revealed: -There was not an entry for the 1 can of nutritional supplement via bolus feed 5 times per day. -There was not an entry for 60 ml flush of water before and after tube feedings. Review of Resident #2's August 2020 eMAR revealed: -There was not an entry for 1 can of nutritional supplement via bolus feed 5 times per day.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 246	Continued From page 2 -There was not an entry for 60 ml flush of water before and after tube feedings. Review of Resident #2's intake documentation from 07/28/20-07/31/20 revealed: -There were written entries for date, time, 7:00am-7:00pm input volume, and 7:00pm-7:00am input volume. -On 07/28/20, 07/29/20, 07/30/20, and 07/31/20, there was documentation on 4 out of 4 days, Resident #2 did not receive his ordered 5 cans of nutritional supplement per day. -For example, on 07/28/20 at 1:00pm, on 07/29/20 at 8:00am, and 07/30/20 at 8:00am, one can of nutritional supplement (240 ml) was documented as administered. -From 07/28/20, 07/29/20, 07/30/20, and 07/31/20, there was documentation on 4 out of 4 days, Resident #2 did not receive his ordered 60 ml flush of water before and after his tube feedings 5 times per day. -For example, on 07/29/20 and on 07/30/20, two flushes (60 ml) were documented as administered at 8:00am. Review of Resident #2's intake documentation from 08/01/20-08/21/20 revealed: -There were written entries for date, time, 7:00am-7:00pm input volume, and 7:00pm-7:00am input volume. -From 08/01/20-08/21/20, there was documentation on 21 out of 21 days Resident #2 did not receive his ordered 5 cans of nutritional supplement per day. -For example, on 08/01/20, one can of nutritional supplement (240 ml) was documented as administered at 11:30am. -For example, on 08/11/20, one can of nutritional supplement (240 ml) was documented as administered at 9:00am, at 12:30pm, and at	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E!	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 246	Continued From page 3 8:00pm. -For example, on 08/12/20, a half can of nutritional supplement (120 ml) was documented as administered at 9:15am and at 2:45pm. -For example, on 08/14/20, one can of nutritional supplement (240 ml) was documented as administered at 9:30am. -For example, on 08/14/20, 130 ml of nutritional supplement was documented as administered at 1:30pm. -For example, on 08/14/20, 137 ml of nutritional supplement was documented as administered at 3:00pm. -For example, on 08/17/20, one can of nutritional supplement (240 ml) was documented as administered at 7:00am and 2:00pm. -For example, on 08/17/20, 200 ml of nutritional supplement (240 ml) was documented as administered at 12:30pm. -There was no documentation of administration of the nutritional supplement on 08/02/20. -From 08/01/20-08/21/20, there was documentation on 21 out of 21 days Resident #2 did not receive his ordered 60 ml flush of water before and after his tube feedings 5 times per day. -For example, on 08/11/20, two flushes (60 ml) were documented as administered at 9:00am, at 12:30pm, and 8:00pm. -For example, on 08/12/20, two flushes (30 ml) were documented as administered at 9:15am and at 2:45pm. -For example, on 08/14/20, two flushes (30 ml each) were documented as administered at 9:30am. -For example, on 08/14/20, two flushes (60 ml) were documented as administered at 1:30pm. -For example, on 08/14/20, two flushes (30 ml and 60 ml) were documented as administered at 3:00pm.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 246	Continued From page 4 -For example, on 08/15/20, two flushes (60 ml) were documented as administered at 7:30pm. Review of Resident #2's Licensed Health Professional Support Initial Evaluation dated 07/30/20 revealed: -His height was 6 feet 2 inches. -His weight was 171.4 lbs. Review of Resident #2's vital signs documentation revealed: -There were written entries for the date, temperature, pulse, respiration, blood pressure, and weight. -The form had documentation of being completed by staff. -On 07/28/20, his weight was 171.4 lbs. -On 07/31/20, his weight was 171.4 lbs. -On 08/03/20, his weight was noted as "refused." -On 08/20/20, his weight was 165.2 lbs. Observation of Resident #2's weight to a standing scale via video conference on 08/24/20 at 4:02pm with the Administrator revealed a weight of 167.2 lbs. Review of Resident #2's progress notes from 07/28/20 to 08/17/20, there was no documentation of PCP notifications related to weight loss. Telephone interview with a Medication Aide (MA) on 08/20/20 at 8:01am revealed: -The Administrator was responsible for notifying the PCP for all residents' needs and any resident health changes. -The MAs cannot have direct contact with the PCP. -The MAs would call the Administrator because "she was the only one that could contact the	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E:	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 246	Continued From page 5 PCP". -She "guessed if necessary" the MA could contact the PCP if the Administrator was not available. Telephone interview with the Administrator on 08/20/20 at 12:40pm revealed: -It was the facility's policy for the Administrator to notify the PCP with any resident's health status changes. -The facility's PCP notification policy was implemented about 3 months ago when 80% of the facility's staff had left. -There was a lot of "confusion" and staff turnover, so the Administrator had been calling the PCP. -If a resident had a health change, it would be reported from a MA to the Administrator immediately. -She was responsible to notify the PCP for any resident health status changes by phone or email. -Monthly weights were completed for all residents. -Resident #2 had only allowed the facility staff to take his weight twice. -His weight today was 165.2 lbs. -She was not aware of the 17.4 lb. weight loss from 07/28/20-08/20/20 based upon the recorded weight on the FL-2 dated 07/28/20. -She had not notified the PCP of Resident #2's weight loss. Telephone interview with Resident #2's PCP on 08/21/20 at 11:30am revealed: -She was not aware Resident #2 had a weight loss of 17.4 lbs. from 07/28/20 to 08/20/20. -She would have expected the facility to have notified her of Resident #2's weight loss due to him not receiving adequate nutrition. -She would have wanted to be notified of the weight loss because the order for his nutritional supplement was calculated based off Resident	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E!	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 246	Continued From page 6 #2's caloric requirements. -The PCP's electronic documentation system, outlined all telephone encounters from the facility to any PCP on the team. -She verified within the electronic documentation system, there was not a telephone encounter or notification from the facility related to Resident #2's weight loss. -Since he was not receiving his required caloric requirements, the outcomes of weight loss could be malnutrition, electrolyte imbalance, and skin integrity issues which could lead to skin breakdown. Telephone interview with Administrator on 08/21/20 at 9:30am revealed: -She had contacted Resident #2's PCP by email on 08/20/20 related to his weight loss. -The Administrator notified Resident #2's PCP his admission weight dated 07/28/20 of 171 lbs. and had decreased to 165.2 lbs. on 08/20/20. -The PCP sent new orders to monitor his weight every two weeks and to notify the PCP of any refusals. Attempted telephone interview with Resident #2 on 08/18/20 at 3:00pm was unsuccessful. Refer to Tag 276 10A NCAC 13. G .0904(e)(4) Nutrition and Food Services. ~~The facility failed to notify Resident #2's primary care provider of a weight loss of 4.2 lbs. from 07/28/20-08/20/20. The facility's failure placed Resident #2 at risk for malnutrition, additional weight loss, electrolyte imbalance, and skin breakdown. This failure was detrimental to the health and safety of the resident which constitutes a Type B Violation.~~	C 246	OT, 04/13/2021, "04/13/2021 Settlement Agreement"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF ES	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 246	Continued From page 7 ~~The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 08/24/20.~~ ~~CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2020.~~	C 246	DT, 04/13/2021, "04/13/2021 Settlement Agreement"	
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: ~~TYPE A2 VIOLATION~~ TYPE B Based on virtual observations, interviews and record reviews, the facility failed to ensure nutritional supplements were served as ordered for 1 of 1 resident sampled (Resident #2) who did not have a regular pattern of oral intake and was ordered a nutritional supplement. The findings are: Review of Resident #2's current FL-2 signed by the physician and dated 07/28/20 revealed: -Diagnoses included urinary retention. -He was intermittently confused. -For his nutrition status, there was a diet order for a mechanical soft diet and gastronomy was checked with "see additional info" written. -There was an order for tube feeds: 1 can of a specified nutritional supplement via bolus feed 5	C 284	DT, 04/13/2021, "04/13/2021 Settlement Agreement"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E!	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 284	Continued From page 8 times per day with 60 milliliter (ml) flush of water before and after feeds. -His weight was documented as 182.6 pounds (lbs.) with a height of 6 feet 2 inches. Review of the manufacture's guidelines for Resident #2's ordered nutritional supplement revealed: -The nutritional supplement was indicated for tube or oral feeding for supplemental or sole-source nutrition to help patients gain and maintain healthy weight. -The supplement was a nutritionally complete, high-calorie formula designed to meet the increased protein and calorie needs of stressed patients and those requiring low-volume feedings. -For tube feeding, additional fluid requirements should be met by giving water between or after feeding or when flushing the tube. -Each 8 ounce can provided 475 calories, 19.9 grams of protein, 21.5 grams of fat, 51.8 grams of carbohydrates, varying amounts of vitamin supplementation such as Vitamins C, D and, varying amounts of mineral supplementation such as potassium, phosphorus, and calcium. -Resident #2's ordered 5 cans of nutritional supplement would have provided a total of 3,800 calories per day. Review of Resident #2's July 2020 electronic medication administration record (eMAR) revealed: -There was not an entry for the 1 can of nutritional supplement via bolus feed 5 times per day. -There was not an entry for 60 ml flush of water before and after tube feedings. Review of Resident #2's August 2020 eMAR revealed:	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E!	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 284	Continued From page 9 -There was not an entry for 1 can of nutritional supplement via bolus feed 5 times per day. -There was not an entry for 60 ml flush of water before and after tube feedings. Review of Resident #2's intake documentation from 07/28/20-07/31/20 revealed: -There were written entries for date, time, 7:00am-7:00pm input volume, and 7:00pm-7:00am input volume. -From 07/28/20- 07/31/20, there was documentation on 4 out of 4 days, Resident #2 did not receive his ordered 5 cans of nutritional supplement per day. -For example, on 07/28/20, one can of nutritional supplement (240 ml) was documented as administered at 1:00pm. -For example, on 07/29/20, one can of nutritional supplement was documented as administered at 8:00am. -For example, on 07/30/20, one can of nutritional supplement was documented as administered at 8:00am. Review of Resident #2's intake documentation from 07/28/20-07/31/20 revealed: -There were written entries for date, time, 7:00am-7:00pm input volume, and 7:00pm-7:00am input volume. -From 07/28/20- 07/31/20, there was documentation on 4 out of 4 days, Resident #2 did not receive his ordered 60 ml flush of water before and after his tube feedings 5 times per day. -For example, on 07/29/20, two flushes (60 ml) were documented as administered at 8:00am. -On 07/30/20, two flushes (60 ml) were documented as administered at 8:00am. Review of Resident #2's intake documentation	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 284	Continued From page 10 from 08/01/20-08/21/20 revealed: -There were written entries for date, time, 7:00am-7:00pm input volume, and 7:00pm-7:00am input volume. -From 08/01/20-08/21/20, there was documentation on 21 out of 21 days Resident #2 did not receive his ordered 5 cans of nutritional supplement per day. -For example, on 08/01/20, one can of nutritional supplement (240 ml) was documented as administered at 11:30am. -For example, on 08/11/20, one can of nutritional supplement was documented as administered at 9:00am, at 12:30pm, and at 8:00pm. -For example, on 08/12/20, a half can of nutritional supplement (120 ml) was documented as administered at 9:15am and at 2:45pm. -For example, on 08/14/20, one can of nutritional supplement was documented as administered at 9:30am. -For example, on 08/14/20, 130 ml of nutritional supplement was documented as administered at 1:30pm. -For example, on 08/14/20, 137 ml of nutritional supplement was documented as administered at 3:00pm. -For example, on 08/17/20, one can of nutritional supplement was documented as administered at 7:00am and 2:00pm. -For example, on 08/17/20, 200 ml of nutritional supplement was documented as administered at 12:30pm. -There was no documentation of administration of the nutritional supplement on 08/02/20. Review of Resident #2's intake documentation from 08/01/20-08/21/20 revealed: -There were written entries for date, time, 7:00am-7:00pm input volume, and 7:00pm-7:00am input volume.	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E!	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 284	Continued From page 11 -From 08/01/20-08/21/20, there was documentation on 21 out of 21 days Resident #2 did not receive his ordered 60 ml flush of water before and after his tube feedings 5 times per day. -For example, on 08/11/20, two flushes (60 ml) were documented as administered at 9:00am and at 12:30pm. -For example, on 08/11/20, one flush (60 ml) was documented as administered at 8:00pm. -For example, on 08/12/20, two flushes (30 ml each) were documented as administered at 9:15am and at 2:45pm. -For example, on 08/14/20, two flushes (30 ml each) were documented as administered at 9:30am and at 1:30pm. -For example, on 08/14/20, two flushes (30 ml and 60 ml) were documented as administered at 3:00pm. -For example, on 08/15/20, two flushes (60 ml) were documented as administered at 7:30am. -For example, on 08/15/20, two flushes (one 30 ml and one 60 ml) were documented as administered at 12:30pm. -There was no documentation of administration of the water flush on 08/02/20. Review of Resident #2's progress notes dated from 07/28/20 to 08/17/20 revealed there was no documentation of physician notification Resident #2 was not administered 5 cans of nutritional supplement, as ordered, per day and no documentation the 60 ml flushes of water ordered before and after each tube feedings were not administered as ordered. Telephone interview with a Medication Aide (MA) on 08/20/20 at 8:01am revealed: -Resident #2 told "us" he only wanted 2-3 cans of tube feeding per day.	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 284	Continued From page 12 -Resident #2's primary care provider (PCP) was aware that he was only receiving 2-3 cans of tube feeding per day rather than the 5 cans per day order because "we told him," when he came to the facility. -She was unsure of when the PCP came to the facility and if any different instructions were given related to the administration of his nutritional supplement for his tube feeding. -The facility staff would offer Resident #2 food, but he did not want "anything." -He would eat crackers but "not really much" and drank water by mouth. -He would not eat solid food. -The Administrator was responsible for notifying the PCP for all residents' needs and any resident health changes. -The MAs cannot have direct contact with the PCP. -The MAs would call the Administrator because "she was the only one that could contact the PCP". -She "guessed if necessary" she could contact the PCP if the Administrator was not available. Telephone interview with Resident #2's PCP on 08/20/20 at 9:30am revealed: -She was not aware Resident #2 was not administered 5 cans of nutritional supplement for his tube feedings as ordered. -She was not aware Resident #2 was only receiving 2-3 cans of nutritional supplement for his tube feeding per day. -She expected the facility to notify her if he was only receiving 2-3 cans of nutritional supplement for his tube feeding per day because he would not be meeting his daily nutritional requirements. -She expected all physician orders to be followed as ordered. -Since he was not receiving his required	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E!	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 284	Continued From page 13 nutritional requirements, the outcomes could be malnutrition, weight loss, electrolyte imbalance, and skin integrity issues which could lead to skin breakdown. -She would have wanted to be notified of the weight loss because the order for his nutritional supplement was calculated based off Resident #2's caloric requirements. Telephone interview with the Administrator on 08/20/20 at 12:40pm revealed: -Resident #2's family member would order his nutritional supplement for his tube feeding and deliver to the facility. -The Home Health Registered Nurse (RN) completed the initial tube feeding training with Resident #2 and her. - "Two nurses" the Home Health RN and herself verified Resident #2 was able to administer his nutritional supplement for his tube feeding by observing and supervising him demonstrate the administration of his tube feedings when he was admitted to the facility. -She administered his nutritional supplement for his tube feedings the initial 2-3 times. -She trained the facility staff on the administration of his nutritional supplement for his tube feeding by a return demonstration. -The goal of training was for Resident #2 to administer his tube feedings with the facility's staff supervision. -For the administration of his nutritional supplement for his tube feedings, it was a combined effort between staff and Resident #2. -Resident #2 administered his daily tube feedings with staff's supervision, he would only administer 2 cans per day. -He said, "That was enough." -The goal for Resident #2 was to be on oral intake, it would not be "overnight."	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E:	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 284	Continued From page 14 -The psychiatric provider would begin working him on 08/21/20 which would be his first visit. -Resident #2 did not have a regular pattern of eating, there were moments he requested oral food. -He was offered food, if he requested something it would be provided to him, for example macaroni and cheese or cereal. -His tube feedings were not scheduled, each day was "different." -It was "let us watch and see kind of thing." -We were planning on discussing the tube feeding order with the PCP during an onsite visit scheduled to facility for 09/03/20. -The current order dated 07/28/20 for Resident #2 to receive 1 can of nutritional supplement via bolus feed 5 times per day with 60 milliliter (ml) flush of water before and after feeds was not "correct." -The order should be "up to 5 cans per day." -She was responsible for implementing and clarifying orders to ensure orders were followed. -She did not notify the PCP the 5 cans of nutritional supplement per day were not being administered. -She" failed" to follow up. Telephone interview with the Resident #2's family member on 08/21/20 at 11:15am revealed: -She was responsible for ordering his prescribed nutritional supplement for his tube feedings through a medical supply provider. -She would re-order his cans of nutritional supplement for his tube feeding 1 week before his supply ran out. -There were 24 cans of nutritional supplement for his tube feeding per box. -On 07/28/20 the date of his admission, she delivered 3 boxes (76 cans total) to the facility. -She was going make a delivery of nutritional	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E!	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 284	Continued From page 15 supplement for his tube feedings to the facility this weekend but had not made a delivery since the 07/28/20 delivery. Observation of Resident #2's nutritional supplement on hand via video conference on 08/24/20 at 9:28am revealed: -There were 3 layers of Resident #2's nutritional supplement tube feeding. -The two bottom layers were unopened and had 24 cans of nutritional supplement on each layer (48 cans). -For the top layer of his nutritional supplement, the plastic covering was open and had 18 cans of his nutritional supplement. -There were 42 cans on hand from the 07/28/20 delivery of 76 cans. Video conference interview with the Administrator on 08/24/20 at 9:28am revealed Resident #2's family member brought 1 case of 24 cans of nutritional supplement to the facility over the weekend. Based on the nutritional supplement order from 07/28/20-08/24/20, Resident #2 was ordered and should have been administered 140 full cans of nutritional supplement. Virtual observations, interviews, and record reviews revealed from 07/28/20-08/24/20, Resident #2 was only administered 34 full or partial cans of the nutritional supplement. Observation of Resident #2's weight to a standing scale via video conference on 08/24/20 at 4:02pm with the Administrator revealed a weight of 167.2 lbs. Attempted observation of a virtual demonstration of Resident #2's tube feeding via video	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 284	Continued From page 16 conference on 08/21/20 at 2:30pm was unsuccessful. Attempted telephone interview with Resident #2 on 08/18/20 at 3:00pm was unsuccessful. Attempted telephone interview with the Home Health Registered Nurse on 08/19/20 at 9:45am, 08/21/20 at 9:48am, and 08/24/20 at 1:01pm was unsuccessful. Refer to Tag 276 10A NCAC 13. G .0902(b) Health Care. The facility failed to ensure nutritional supplements were administered as ordered to Resident #2 who did not have a regular oral intake and was ordered 5 cans of a nutritional supplement daily via his gastrostomy feeding tube. Based on the nutritional supplement order, from 07/28/20-08/24/20, Resident #2 was ordered and should have been administered 140 full cans of nutritional supplement. From 07/28/20-08/24/20, Resident #2 was only administered 34 full or partial cans of the nutritional supplement resulting in the resident not receiving the caloric and protein intake prescribed, placing him at risk for continued malnutrition, additional weight loss, electrolyte imbalance, and skin breakdown. The facility's failure ~~placed the resident at substantial risk for serious physical harm and neglect and constitutes a Type A2 Violation~~ was detrimental to the health and safety of the resident which constitutes a Type B Violation, DT, 04/13/2021, "04/13/2021 Settlement Agreement" The facility provided Plan of Protection in accordance with G.S. 131D-34 on ~~09/03/20.~~ 08/24/20. DT, 04/13/2021, "04/13/2021 Settlement Agreement" CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER ~~5,~~ 26 2020. DT, 04/13/2021, "04/13/2021 Settlement Agreement"	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E:	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents sampled (#2, #3) including errors with crushing and administering medications via a gastrostomy tube without an order including with medications for heart/blood pressure, underactive thyroid, blood clot prevention, anxiety, an antipsychotic, and constipation (#2); and errors with a blood pressure medication (#3). The findings are: 1. Telephone interview with a medication aide (MA) on 08/17/20 at 9:30am revealed: -Resident # 2 had anxiety with swallowing. -He was administered his medications through his gastronomy tube (G-tube). Second telephone interview with the MA on 08/19/20 at 3:05pm revealed: -Resident #2's routine medications were administered through his G-tube.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 330	Continued From page 18 -His routine medications were ordered to be administered via the G-tube. -She was unsure who had written the order for G-tube administration. -That was the "only" way he would take his medications. -He refused his medications any way other than his G-tube. -She was not sure if the primary care provider (PCP) was notified, he had refused to take his ordered medications orally. Third telephone interview with the MA on 08/20/20 at 8:01am revealed: -Resident #2 had a problem with swallowing, he took everything through his G-tube. -She administered his medication through his G-tube. -She would crush his medications, place them in water, and administer through his G-Tube. Review of Resident #2's physician's orders revealed: -There was no order to crush the resident's medications. -There was no order to administer the resident's medications via the G-tube. Telephone interview with the Manager of Pharmacy Operations for the facility's contracted pharmacy on 08/19/20 at 12:15pm revealed: -There was not a physician order within the pharmacy's ordering system to crush Resident #2's medications: Levothyroxine 200 mcg by mouth daily, Lisinopril 20 mg by mouth daily, Polyethylene glycol 17 grams daily, Xarelto 10 mg, Quetiapine 12.5 mg by mouth at bedtime, and Lorazepam 1 mg by mouth twice a day. -There was not a physician order within the pharmacy's ordering system to administer	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E!	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 330	Continued From page 19 Resident #2's medications Levothyroxine 200 mcg daily, Lisinopril 20 mg daily, Polyethylene glycol 17 grams daily, Xarelto 10 mg daily, Quetiapine 12.5 mg by mouth at bedtime, and Lorazepam 1 mg twice a day via his G-tube. -Lorazepam solution 2 mg/ml concentration give 0.2 ml via G-tube twice a day as needed was the only medication ordered to be administered via his G-tube. -It would be important for the facility to obtain a physician order related to crushing his medications because how would the facility know the medications were appropriate to crush and administer via his G-tube. Telephone interview with the Administrator on 08/20/20 at 12:40pm revealed: -She was responsible for implementing and clarifying orders to ensure orders were followed. -The facility's contracted pharmacy would add the new medication to the electronic medication administration (eMAR). -She did complete resident chart audits when she was not staffing. - It had been "awhile" since she completed a chart audit. -She had not done a chart audit since Resident #2 came to the facility. -Resident #2's medications were administered through his G-tube. -His medication orders were ordered to be given by mouth. -There was not a PCP order to crush his medications. -The PCP was not aware his medications were being crushed. -The PCP was not aware Resident #2 was not receiving his medications by mouth. -It was an "oversight" on her part."	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF ES	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 330	Continued From page 20 Telephone interview with Resident #2's PCP on 08/20/20 at 9:30am revealed: -She was not aware Resident #2's ordered medications were being crushed and administered via his G-tube. -She expected the facility to notify the PCP so the order could be clarified and changed. -She expected the facility to obtain a clarification to the physician order to verify if it was appropriate to crush his medications. -She expected all physician orders to be followed as ordered. -She expected the medication orders to be followed due to it being a part of the resident's rights of medication administration: right resident, right drug, right dose, right time, and right route. a. Review of Resident #2's current FL-2 dated 07/28/20 revealed a medication order for Levothyroxine 200 mcg by mouth once daily (Levothyroxine is used to treat an underactive thyroid). Review of Resident #2's July 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Levothyroxine 200 mcg by mouth daily with scheduled administration at 8:00am. -Levothyroxine was documented as administered 2 out of 3 opportunities from to 07/29/20-07/30/20. -There was documentation he refused the 07/31/20 dose of Levothyroxine. Review of Resident #2's August 2020 eMAR revealed: -There was an entry for Levothyroxine 200 mcg by mouth daily with scheduled administration at 8:00am.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E!	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 330	Continued From page 21 -Levothyroxine was administered 6 out of 17 opportunities from 08/02/20-08/17/20. -There was documentation he refused the 08/01/20 dose of Levothyroxine. Attempted telephone interview with Resident #2 on 08/18/20 at 3:00pm was unsuccessful. Refer to telephone interview with the Administrator on 08/21/20 at 9:30am. b. Review of Resident #2's current FL-2 dated 07/28/20 revealed a medication order for Lisinopril 20 mg by mouth once daily (Lisinopril is used to high blood pressure). Review of Resident #2's July 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Lisinopril 20 mg by mouth daily with scheduled administration at 8:00am. -Lisinopril was administered 2 out of 3 opportunities from 07/29/20-07/30/20. -There was documentation he refused the 07/31/20 dose of Lisinopril. Review of Resident #2's August 2020 eMAR revealed there was an entry for Lisinopril 20 mg by mouth daily with scheduled administration at 8:00am and documentation of administration for 17 out of 17 opportunities from 08/01/20-08/17/20. Attempted telephone interview with Resident #2 on 08/18/20 at 3:00pm was unsuccessful. Refer to telephone interview with the Administrator on 08/21/20 at 9:30am. c. Review of Resident #2's current FL-2 dated	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 330	Continued From page 22 07/28/20 revealed a physician's order for Polyethylene glycol 17 gram by mouth once daily (Polyethylene glycol is used to treat occasional constipation). Review of Resident #2's July 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Polyethylene glycol powder 17 grams by mouth daily with scheduled administration at 8:00am. -Polyethylene glycol powder was administered 2 out of 3 opportunities from 07/29/20-07/30/20. -There was documentation he refused the 07/31/20 dose of Polyethylene glycol powder. Review of Resident #2's August 2020 eMAR revealed there was an entry for Polyethylene glycol powder 17 grams by mouth daily with scheduled administration at 8:00am and documentation of administration for 17 out of 17 opportunities from 08/01/20-08/17/20. Attempted telephone interview with Resident #2 on 08/18/20 at 3:00pm was unsuccessful. Refer to telephone interview with the Administrator on 08/21/20 at 9:30am. d. Review of Resident #2's current FL-2 dated 07/28/20 revealed a physician's order for Xarelto 10 mg by mouth once daily (Xarelto is used to treat and prevent blood clots). Review of the manufacturer's administration guidelines for the administration of Xarelto through a G-tube revealed: -Confirm tube placement. -Suspend crushed Xarelto in 50 ml of water. -Avoid administration to distal stomach.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E!	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 330	Continued From page 23 Review of Resident #2's July 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Xarelto 10 mg by mouth daily with scheduled administration at 8:00am. -Xarelto was administered 2 out of 3 opportunities from 07/29/20-07/30/20. -There was documentation he refused the 07/31/20 dose of Xarelto. Review of Resident #2's August 2020 eMAR revealed there was an entry for Xarelto 10 mg by mouth daily with scheduled administration at 8:00am and documentation of administration for 17 out of 17 opportunities from 08/01/20-08/17/20. Attempted telephone interview with Resident #2 on 08/18/20 at 3:00pm was unsuccessful. Refer to telephone interview with the Administrator on 08/21/20 at 9:30am. e. Review of Resident #2's physician's order dated 07/31/20 revealed a medication order for Quetiapine 12.5 mg by mouth at bedtime (Quetiapine is used to treat schizophrenia, bipolar disorder, and depression). Review of Resident #2's August 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Quetiapine 12.5 mg by mouth at bedtime scheduled for administration at 8:00pm. -Quetiapine was administered 13 out of 13 opportunities from 08/05/20-08/17/20. Telephone interview with a MA on 08/20/20 at	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF ES	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 330	Continued From page 24 8:01am revealed: -She was responsible for administering medications (Lorazepam 1mg by mouth twice a day and Quetiapine 12.5 mg by mouth at bedtime) to Resident #2 on 08/04/20, 08/05/20, 08/06/20, 08/07/20, 08/10/20, 08/13/20, 08/14/20, 08/15/20, and 08/16/20 as indicated by her initials on the MAR. -He had a problem with swallowing, he took everything through his G-tube. -She administered his medication through his G-tube. -That was what he "liked." -She would crush his medications, plae them in water, and administer through his G-tube. -There was no response to the question if the medication orders were accurate and complete related to preparation and route administration. -She "thought" the physician knew Resident #2's medications were crushed and given via G-tube. Attempted telephone interview with Resident #2 on 08/18/20 at 3:00pm was unsuccessful. Refer to telephone interview with the Administrator on 08/21/20 at 9:30am. f. Review of Resident #2's physician's order dated 07/31/20 revealed Lorazepam 1 mg by mouth twice a day (Lorazepam is used to treat anxiety). Review of Resident #2's August 2020 electronic medication administration record (eMAR) revealed there was an entry for Lorazepam 1 mg by mouth twice a day scheduled for administration at 8:00am and 8:00pm and documentation of administration for 28 out of 28 opportunities from 08/04/20-08/17/20. Telephone interview with a MA on 08/20/20 at	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E!	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 330	Continued From page 25 8:01am revealed: -She was responsible for administering medications (Lorazepam 1mg by mouth twice a day and Quetiapine 12.5 mg by mouth at bedtime) to Resident #2 on 08/04/20, 08/05/20, 08/06/20, 08/07/20, 08/10/20, 08/13/20, 08/14/20, 08/15/20, and 08/16/20 as indicated by her initials on the MAR. -He had a problem with swallowing, he took everything through his G-Tube. -She administered his medication through his G-tube. Attempted telephone interview with Resident #2 on 08/18/20 at 3:00pm was unsuccessful. Refer to telephone interview with the Administrator on 08/21/20 at 9:30am. Telephone interview with Administrator on 08/21/20 at 9:30am revealed: -She had contacted Resident #2's PCP by email on 08/20/20. -She requested to change the route of medication administration to G-tube if resident was unable to tolerate the oral route from Resident #2's PCP. -She requested a crush order for appropriate medications so they could be administered through his G-tube from Resident #2's PCP. 2. Review of Resident #3's current FL-2 dated 05/11/20 revealed: -Diagnoses included dementia, chronic obstructive pulmonary disease, hypertension, hypothyroidism, Type II diabetes mellitus, major depressive disorder, insomnia, and anemia. -An order for Lisinopril (a medication used to treat hypertension) 40 mg once daily by mouth in the morning, hold if SBP (systolic blood pressure)	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 330	Continued From page 26 less than 100 or DBP (diastolic blood pressure) less than 60. Review of Resident #3's July 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Lisinopril 40 mg, take one tablet every morning, hold if SBP less than 100 or DBP less than 60. -There was documentation that Lisinopril 40 mg was administered on 3 of 31 opportunities when the blood pressure was outside of ordered parameters (on 07/01/20, 07/30/20, and 07/31/20). -There was documentation that Resident #3's blood pressure at 8:00am was 135/56 on 07/01/20, 145/54 on 07/30/20, and 145/54 on 07/31/20. Review of Resident #3's August 2020 eMAR revealed: -There was an entry for Lisinopril 40 mg, take one tablet every morning hold if SBP less than 100 or DBP less than 60. -There was documentation that Lisinopril 40 mg was administered on 2 of 17 opportunities when the blood pressure was outside of the ordered parameters (on 08/01/20 and 08/02/20). -There was documentation that Resident #3's blood pressure at 8:00am was 145/54 on 08/01/20 and 145/54 on 08/02/20. Telephone interview with a medication aide (MA) on 08/19/20 at 3:05pm revealed: -Resident #3's Lisinopril order had parameters which meant to hold the medication if SBP was less than 100 or DBP was less than 60. -She thought the process was to skip over the medication and leave the entry blank if the medication was held.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 330	Continued From page 27 -She was responsible for administering medications to Resident #3 on 07/31/20, 08/01/20, and 08/02/20 as indicated by her initials on the MAR. -"I think I clicked it even though I didn't give it". -Based on Resident #3's blood pressures on 07/31/20, 08/01/20, and 08/02/20 the Lisinopril should not have been administered. Telephone interview with a second MA on 08/20/20 at 8:01am revealed: -Resident #3's Lisinopril order had parameters which meant to hold the medication if SBP was less than 100 or DBP was less than 60. -She was responsible for administering medications to Resident #3 on 07/30/20 as indicated by her initials on the MAR. -If there was no circle around her initials on the MAR then she gave the medication. -Based on Resident #3's blood pressure on 07/30/20 the Lisinopril should not have been administered. Telephone interview with Resident #3's Primary Care Provider (PCP) on 08/20/20 at 9:30am revealed: -Resident #3's Lisinopril order had parameters which meant to hold the medication if SBP was less than 100 or DBP was less than 60. -Resident #3 had parameter orders to hold the Lisinopril to prevent hypotension. -She was not aware that the Lisinopril doses were given even though they should have been held based on blood pressures for 07/01/20, 07/30/20, 07/31/20, 08/01/20, and 08/02/20. -She expected medication orders to be followed and would expect to be notified if they were not followed as ordered. Telephone interview with Administrator on	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF ES	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 330	Continued From page 28 08/20/20 at 12:40pm revealed: -Resident #3's Lisinopril order had parameters which meant to hold the medication if SBP was less than 100 or DBP was less than 60. -Based on Resident #3's blood pressure on 07/01/20, 07/30/20, 07/31/20, 08/01/20, and 08/02/20 the Lisinopril should have been held. -She expected all physician orders to be followed as ordered. -She was responsible for chart audits and did not have a current plan in place for completing them. -She hadn't completed a chart audit since before 07/28/20. The facility failed to ensure medications were administered as ordered including Resident #2's medications which were crushed without a physician's order and administered via a gastrostomy tube without a physician's order, placing the resident at risk of complications and/or side effects from receiving medications that should not be crushed and/or administered via a gastrostomy tube. Resident #3 was administered a medication to lower blood pressure on 5 occasions when the blood pressure was outside of the parameters of the order, resulting in the resident being at increased risk for hypotension. The facility's failure was detrimental to the health and safety of the residents which constitutes a Type B Violation. The facility provided Plan of Protection in accordance with G.S. 131D-34 on 08/24/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2020	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E!	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 914	Continued From page 29	C 914		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on virtual observations, interviews and record reviews, the facility failed to ensure residents were free of neglect related to nutrition and food service, health care, and medication administration. The findings are: 1. Based on virtual observations, interviews and record reviews, the facility failed to ensure nutritional supplements were served as ordered for 1 of 1 resident sampled (Resident #2) who did not have a regular pattern of oral intake and was ordered a nutritional supplement. [Refer to Tag 284, 10A NCAC 13G .0904(e)(4) Nutrition and Food Service (Type ~~A2~~ B Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents sampled (#2, #3) including errors with crushing and administering medications via a gastrostomy tube without an order including errors with medications for heart/blood pressure, underactive thyroid, blood clot prevention, anxiety, an antipsychotic, and constipation (#2); and errors with a blood pressure medication (#3). [Refer to Tag 330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)]. ~~3. Based on virtual observations, interviews, and record reviews, the facility failed to assure referral and follow up for acute and routine health care~~	C 914	DT, 04/13/2021, "04/13/2021 Settlement Agreement" DT, 04/13/2021, "04/13/2021 Settlement Agreement"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092266	A. BUILDING: _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENAISSANCE CARE HOME AT LONGLEAF E	3352 LONGLEAF ESTATES DR RALEIGH, NC 27616

(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
C 914	Continued From page 30 ~~needs for 1 of 3 sampled residents (#2) related to notifying the primary care provider (PCP) of weight loss. [Refer to Tag 246, 10A NCAC 13G .902(b) Health Care (Type B Violation)].~~	C 914	DT, 04/13/2021, "04/13/2021 Settlement Agreement"	