NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

May 18, 2021

Mr. Maurice Achu, Licensee
Rising Hope Health Care Services
233 Ghoulson Ave
Henderson, NC 27536

email address: *mauriceachu@yahoo.com*

Re: Receipt of Plan of Correction (Event ID TMLV11)
Facility: Rising Hope Health Care Services
Licensure Number: FCL-091-017
County: Vance

Dear Mr. Achu:

Based on our telephone conversation on May 18, 2021, there was an addendum to the Plan of Correction for the Statement of Deficiencies dated April 13, 2021. The pages noting the addendum are provided for your records.

Please do not hesitate to contact us at 984-365-2578, if you have questions or we may be of further assistance.

Sincerely,

Shonda Stacey

Shonda Stacey, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosure

cc: Artelia Trice, Supervisor, **Vance** County DSS
Bridget Rackley, Central Branch Manager, Central Branch Regional Office, Adult Care Licensure Section
Raleigh Facility File

Attached here is a complete fire and sanitation inspection result.

Sincerely
Maurice Achu
Administrator
Rising Hope Healthcare Services
919-931-8792

N.C. Department of Health and Human Services
Division of Public Health
Environmental Health Section

Inspection of Residential Care Facility

(For facilities, as defined, with not more than 12 residents)

Total Demerits: -8
Date of Insp/Chg 4/19/21
Status Code: A

Health Department Vance
Current Facility ID 040914300067
Old Facility ID

Water Supply: [X] Municipal/Community [ ] On-Site
Wastewater System: [X] Municipal/Community [ ] On-Site

Water sample taken today? [ ] Yes [ ] No
[ ] Inspection [ ] Name Change
[ ] Re-Inspection [ ] Verification of Closure
[ ] Visit [ ] Status Change

Name of Establishment: Rising Hope Health Care
Location Address: 233 Gholson Ave
City: Henderson **State:** NC **Zip:** 27536

Permittee: Maurice Achu
Number of Residents: 6
Mailing Addr.
City: **State:** **Zip:**

Classification:
[X] Approved (20 or less demerits, and no 6-point demerits)
[ ] Provisional (More than 20, but 40 or less demerits, or a 6-point demerit)
[ ] Disapproved (More than 40 demerits or failure to improve provisional classification)

	Demerits	COMMENTS
1. **WATER SUPPLY: Public supply; private supply approved 6 (.1611)**		City Water
2. **LIQUID WASTES: Sewage and other liquid wastes disposed of by approved method 6 (.1613)**		City Sewer
3. **FOOD SUPPLIES AND PROTECTION: Supplies: All food clean, wholesome, no spoilage 6 (.1619) Protection:** Adequate during storage, preparation and serving, potentially hazardous food 45°F or below, or 140°F or above 5; all refrigerators with thermometers 2; pork, ground beef products, poultry and stuffings, etc., thoroughly cooked; meat and poultry salad, potato salad, etc., handled as required, no re-serving of portions once served to an individual 4; food containers stored above floor and protected from contamination 2; pets and other animals not allowed where food is prepared or stored, nor in serving area (unless caged or otherwise restricted) 4 (.1620)		No food prep at time of inspection Hot water @ 110°F
4. FOOD SERVICE UTENSILS AND EQUIPMENT: Food service utensils and equipment in good repair and kept clean 4; eating and drinking utensils clean to sight and touch, cleaned after each use; approved facilities 4; clean utensils properly stored 2; **substances containing poisonous material not used for cleaning or polishing eating or cooking utensils 6**; disposable items properly stored and handled, used only once 2 (.1618)		Refrigerator @ 40°F
5. FOOD SERVICE PERSONS: Clean clothes, hands, and work habits 4 (.1621)		
6. DRINKING WATER FACILITIES: ICE HANDLING: Common drinking cups not used 4; ice, if provided, handled and dispensed in a sanitary manner 2 (.1612)		#11 Floors and baseboards are worn. Chipping paint on baseboards
7. HOT AND COLD WATER: Adequate hot and cold water piped to points of use 4 (.1611)		
8. TOILET: HANDWASHING: LAUNDRY AND BATHING FACILITIES: Toilet, lavatory and bathing facilities adequate 4; fixtures in good repair and kept clean 2; soap and towels provided 2 (.1610)		
9. BEDS: LINEN: FURNITURE: All furniture, mattresses, linen, drapes, blinds and similar items in good repair and clean 2; bed linen changed as required 2; clean and soiled linens properly stored and handled 2 (.1617)		#12 Ceiling repair needed in bathroom. Cracked walls.
10. STORAGE: MISCELLANEOUS: Rooms or areas provided for storage of clothes, personal effects, luggage, supplies and equipment kept clean 2; medications, cleaning supplies, pesticides and other hazardous products properly stored as required 4 (.1616)		#14 Need to mow grass in back yard.
11. FLOORS: In good repair 1; kept clean 2 (.1607)	-3	
12. WALLS AND CEILINGS: In good repair 1; kept clean 2 (.1608)	-3	
13. LIGHTING AND VENTILATION: Windows and fixtures in good repair 1; kept clean 2 (.1609)		
14. VERMIN CONTROL: PREMISES: Outside openings effectively screened or otherwise protected against entrance of flying insects, and flying insects absent 4; effective control of rodents and other vermin 4; approved pesticides properly used 4; premises neat, clean, drained and free of litter and vermin harborages and breeding areas 2 (.1615)	-2	
15. SOLID WASTES: Garbage in standard containers, properly covered and stored, approved disposal 4; containers, storage area kept clean 2; dry rubbish in suitable receptacles, approved storage and disposal 2 (.1614)		

Rept Received by: Maurice Achu
Inspection by: [illegible]
TOTAL DEMERITS -8
EHS I.D.# 1754
Comment Sheet Attached [ ] Yes [X] No

Purpose: General Statute 130A-205 requires the Commission for Public Health to adopt rules governing the sanitation of institutions. 15A NCAC 18A .1605 specifies the contents of an inspection form to record the results of inspections made of residential care facilities. This form is to be used in making inspections of residential care facilities. **Preparation:** Local environmental health specialists shall complete the form every time they conduct an inspection. Prepare an original and three copies for: **1.** Original to the person in charge. **2.** One copy for the supervising agency (or more as requested). **3.** Copy for the local health department. **Disposition:** Please refer to Records Retention and Disposition Schedule 8.B.6., for County/District Health Departments which is published by the North Carolina Division of Archives & History. **Additional forms may be ordered from:** Environmental Health Section, 1632 Mail Service Center, Raleigh, NC 27699-1632, (Courier 52-01-00)

0400

City of Henderson
Fire Inspection Report/Invoice
211 Dabney Drive
Henderson, NC 27536

Page 1 of 1

Square Footage 3,000

Number of Units

Occupant Load

PAYMENT IS DUE WITHIN 30 DAYS OF INSPECTION DATE.

Business Name: Rising Hope Care	**Phone:** 919-931-9792
Address: 223 Gholston Ave.	
Emergency Contact:	**Phone:**
Mailing Address: Same	
Property Mgmt.:	**Phone:**

704 Placard Red ☐ Yellow ☐ White ☐ Blue ☐

Inspection Type	Occ. Class	Date	Time In	Time Out	Fee Applied	Next Reinspection Due
Initial	R-3	4/15/21			$ 55.00	

☐ **No Deficiencies Noted** ☐ **Please correct the listed violation(s) on or before the date listed**

VIOLATIONS: CODE/DESCRIPTION

Item	Location	
		Fire Alarm System Need to be Serviced every year
		Do not use Drop Cords
		Have Fire Alarm test Records uploaded to "The Compliance Engine"

JSR

Inspected By: [signature] **Shift / Admin** **Violations corrected on** 5-3-21

• Extinguishers: 2 / 21 • Extinguishing Sys: ___/___ • Sprinklers: ___/___ • Fire Alarm: ___/___ • Kitchen Hood Cleaned: ___/___

Methods of Payment:

- **Pay in Person** at City Municipal Building, 134 Rose Avenue. The City accepts cash, checks, money orders, credit cards (VISA, MasterCard, & Discover) and debit cards. *Please make check payable to City of Henderson and note invoice # on check.*
- **By Mail** to PO Box 1434, Henderson, NC 27536

The City of Henderson is mandated to conduct periodic inspections of all commercial, educational, institutional, and multi- family residential buildings to ensure compliance with fire and life safety regulations and per City Ordinance 13-38, you will be charged the applicable fee. Its purpose is to identify violations of the State of North Carolina Fire Prevention Code, and activities and conditions in buildings, structures and premises that pose dangers of fire, explosions or related hazards. The inspection was intended to be thorough and complete; however, not all violations of the code may have been identified. Failure to comply may result in civil penalties as per City Ordinance 12-3. The Fire Department and City assumes no responsibilty for damages or injuries from violations of the North Carolina State Fire Code.

By signing this report, you are acknowledging that these violations have been brought to your attention and that you will comply or forward this report to the appropriate representative for compliance.

Owner/Occupant (Print Name) Maurice Allen **Signature** _____ **Date:** 4/15/21

Fire Department (252) 438-7315 Fax (252) 438-1460

RECEIVED
MAY 14 2021
PRINTED: 04/23/2021
FORM APPROVED
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
	FCL091017	A. BUILDING: ADULT CARE LICENSURE SECTION RALEIGH B. WING	R 04/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISING HOPE HEALTH CARE SERVICES	233 GHOLSON AVENUE HENDERSON, NC 27536

(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 annual and follow-up survey on April 13, 2021.	C 000	With reference to 10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination, upon admission into a family care home, this deficiency has been corrected and a copy has been filed to the resident record.	4/14/21
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#2) had completed tuberculosis (TB) testing upon admission in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #2's current FL-2 dated 04/10/21 revealed diagnoses included congestive heart failure, atrial fibrillation, chronic leg ulcer, hypertension, and hyperlipidemia. Review of Resident #2's tuberculosis (TB) skin test revealed there was no documentation of a TB skin test .	C 202	The administrator shall ensure that any new admission to the facility must have a TB skin test. An admission checklist has been made by the administrator to ensure this does not happen again.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maurice Achy
TITLE: Administrator
(X6) DATE: 5/12/2021

Reviewed and accepted with revisions- SS- 5/18/21

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	FCL091017	A. BUILDING: _____ B. WING _____	R 04/13/2021

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C 202	Continued From page 1 Interview with Resident #2 on 04/13/21 at 5:15 pm revealed: -He thought he had a TB skin test completed in the hospital prior to his admission to the facility in 2020. -He thought the TB skin test was negative. -He used his mobile phone to look at his personal medical file online for a local medical provider, but he did not see a TB skin test result in his file. Interview with the Administrator/medication aide (MA) on 04/13/21 at 4:00pm revealed: -He thought Resident #2 had a TB skin test upon admission in April 2020. -He did not know where the documentation for Resident #2's TB skin test was located and thought it was in Resident #2's record. -He had thinned the residents' records and Resident #2's TB skin test was possibly upstairs. -He was responsible for ensuring residents had a completed TB skin test upon admission to the facility.	C 202		
C 212	10A NCAC 13G .0703 (a) Resident Register 10A NCAC 13G .0703 Resident Register (a) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the home. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form	C 212	With reference to 10A NCAC 13G .0703(a) Resident Register, Every resident must have a resident register in their record within 72 hours upon admission. This deficiency has been corrected. The administrator will ensure that all residents must have a resident register in their record as stipulated in the above rule and within the specified hours upon admission, the administrator will use resident information to complete the register.	4/15/21

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C 212	Continued From page 2 other than the Resident Register as long as it contains at least the same information as the Resident Register. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Resident Register was completed within 72 hours of admission for 2 of 3 sampled residents (#2 and #3). The findings are: 1. Review of Resident #2's current FL-2 dated 04/10/21 revealed diagnoses included congestive heart failure, atrial fibrillation, chronic leg ulcer, hypertension, and hyperlipidemia. Review of Resident #2's record revealed there was no resident register. Interview with Resident #2 on 04/13/21 at 9:35am revealed: -He was admitted to the facility after a hospitalization. -He did not know the exact date in 2020 that he was admitted to the facility. Refer to interview with the Administrator/medication aide (MA) on 04/13/21 at 3:00pm. 2. Review of Resident #3's current FL-2 dated 05/28/20 revealed diagnoses included schizophrenia and alcohol abuse. Review of Resident #3's record revealed there was no resident register. Interview with Resident #3 on 04/13/21 at 10:20am revealed:	C 212	To ensure this does not happen again the administrator will periodically review the family care home rulebook to be updated with all rules in the family care home. Resident Registers were added to the two residents records. 5/18/21-SS amended	

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C 212	Continued From page 3 -He was admitted during the global pandemic. -He was admitted from a psychiatric hospital, but he could not remember the month in 2020 when he came to the facility. Refer to interview with the Administrator/medication aide (MA) on 04/13/21 at 3:23pm. Interview with the Administrator/medication aide (MA) on 04/13/21 at 3:23pm revealed: -He knew he was supposed to complete a new resident's register within 72 hours of admission. -He had not completed the Resident Registers for the residents who were admitted in 2020 because of the global pandemic. -He was trying to do what was needed in response to the global pandemic and forgot to complete the Resident Registers.	C 212		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion,	C 231	With reference to 10A NCAC 13G .0801(b) Resident Assessment, this deficiency has been corrected. A resident assessment has been completed and signed by their physician. Document in resident record. The administrator will ensure that all resident assessment and care plans are done annually and on due date in accordance to the above rule. The administrator will ensure that the assessment will be completed following admission and annually following admission and thereafter to determine a resident's level of functioning.	5/10/21

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C 231	Continued From page 4 transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2, and #3) had an assessment and care plan updated annually. The findings are: 1. Review of Resident #1's current FL-2 dated 12/12/20 revealed diagnosis included diabetes mellitus, schizophrenia, obsessive compulsive disorder, hyperlipidemia, hypertension, and hepatitis C. Review of Resident #1's record revealed there was no care plan. Interview with Resident #1 on 04/13/21 at 9:10am revealed he had resided at the facility for 6 or 7 years. Refer to interview with the Administrator on 04/13/21 at 4:06pm. 2. Review of Resident #2's current FL-2 dated 04/10/21 revealed diagnoses included congestive heart failure, atrial fibrillation, chronic leg ulcer, hypertension, and hyperlipidemia. Review of Resident #2's record revealed there was no care plan.	C 231		

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C 231	Continued From page 5 Interview with Resident #2 on 04/13/21 at 9:35am revealed: -He was admitted during the global pandemic last year. -He had improved since coming to the facility, because he needed a lot of assistance when he was first admitted. -He utilized a walker but now he walked a couple of miles per day. Refer to interview with the Administrator on 04/13/21 at 4:06pm. 3. Review of Resident #3's current FL-2 dated 05/28/20 revealed diagnoses included schizophrenia and alcohol abuse. Review of Resident #3's record revealed there was no current or previous care plan. Interview with Resident #3 on 04/13/21 at 10:20am revealed: -He was able to dress himself, trim his own hair, and clip his fingernails and toenails. -The staff provided him with his medications and food. Refer to interview with the Administrator on 04/08/21 at 2:06pm. Interview with the Administrator on 04/13/21 at 4:06pm revealed: -He had not completed new care plans for any of the residents. -He knew he was supposed to update residents' care plans annually. -He forgot to complete them in 2020 and in 2021. -He was responsible for ensuring resident care plans were updated annually and the physician signed the care plans.	C 231		

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C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure blood pressure (BP) checks were implemented and documented as ordered for 2 of 3 sampled residents with orders for weekly BP checks (Resident #1) and monthly BP checks (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 12/12/20 revealed: -Diagnoses included diabetes mellitus, schizophrenia, obsessive compulsive disorder, hyperlipidemia, hypertension, and hepatitis C. -There was an order for weekly blood pressure (BP) monitoring. Review of Resident #1's February, March, and April 2021 medication administration record (MAR) revealed: -There was no entry for weekly BPs and there was no documentation of BPs for Resident #1. -There was no documentation of refusals of BPs for Resident #1. Review of Resident #1's record for	C 249	With reference to 10A NCAC 13G .0902(c)(3)(4) Health Care, the facility Rising Hope Healthcare Services shall ensure that all written orders or procedures by a physician or order license by a healthcare professional should be in resident record. The administrator will periodically review resident records to ensure that FL2, MAR, or other written orders match with resident records and physician orders. The administrator will ensure that all care given to residents is documented in residents' record. E.g blood sugar reading, bp reading, temperature check and other care given.	

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C 249	Continued From page 7 documentation of BPs revealed there was no documentation of weekly BPs for February, March and April 2021. Observation of the facility on 04/13/21 at 4:20pm revealed there was an automatic wrist BP cuff available for use and the Administrator went upstairs to retrieve it. Observation of Resident #1 on 04/13/21 at 4:24pm revealed Resident #1's blood pressure measured 119/74 using the wrist BP cuff. Interview with Resident #1 on 04/13/21 at 3:59pm revealed he did not have his BP monitored at the facility, and he only had his BP obtained at his primary care provider's (PCP) office. Telephone interview with a nurse at Resident #1's PCP's office on 04/13/21 at 2:02pm revealed: -Resident#1 had BP ordered weekly because he has a history of hypertension. -The PCP reviewed the BP measurements Interview with the Administrator on 04/13/21 at 4:40pm revealed: -He reviewed residents' FL-2s after the physician signed the document. -He did not notice Resident #1's PCP ordered weekly BP checks on his FL-2 dated 12/12/20. -He had not monitored Resident #1's BP weekly. Refer to interview with the Administrator on 04/13/21 at 4:40pm. 2. Review of Resident #3's current FL-2 dated 05/28/20 revealed: -Diagnoses included schizophrenia and alcohol abuse. -There was an order for monthly blood pressures.	C 249		

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C 249	Continued From page 8 Review of Resident #3's February, March, and April 2021 medication administration record (MAR) revealed: -There was no entry for weekly blood pressures and there was no documentation of blood pressures for Resident #3 -There was no documentation of refusals of blood pressures for Resident #3. Review of Resident #3's record for BP documentation revealed there was no documentation of monthly blood pressures for February, March or April 2021. Observation of Resident #3 on 04/13/21 at 5:00pm revealed Resident #3's blood pressure measured 144/95 using the wrist BP cuff. Telephone interview with a nurse at Resident #3's primary care provider (PCP) on 04/13/21 at 2:02pm revealed: -Resident #3's blood pressure was monitored because he took olanzapine. -The use of olanzapine caused some individuals to have higher blood pressures. Interview with Resident #3 on 04/13/21 at 10:20am revealed: -He did not have his blood pressure obtained at the facility. -His blood pressure was obtained at his PCP's office. Interview with the Administrator on 04/13/21 at 4:40pm revealed: -He did not notice Resident #3's PCP ordered monthly BP checks on his FL-2 dated 05/28/20. -He had not monitored Resident #3's BP monthly.	C 249		

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C 249	Continued From page 9 Refer to interview with the Administrator on 04/13/21 at 4:40pm. _____ Interview with the Administrator on 04/13/21 at 4:40pm revealed he was responsible for ensuring residents' blood pressure was checked and documented.	C 249		
C 252	10A NCAC 13G .0903(a) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (a) A family care home shall assure that an appropriate licensed health professional, participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage);	C 252	With reference to 10A NCAC 13G .0903(a) Licensed Health Professional Support, this deficiency has been corrected. Documents in residents' record The administrator has made arrangements with a healthcare professional for a quarterly review and reassessment. The administrator will make sure that this is carried out quarterly; the next due date for LHPS Review is 8/2/21. The administrator will ensure that this is carried out by setting a reminder to ensure that this deficiency does not happen again.	5/2/21

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C 252	Continued From page 10 (10) care for pressure ulcers, up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections as stated in Rule .1004(q) of this Subchapter; (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph (14) of this Paragraph); (21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or	C 252		

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C 252	Continued From page 11 non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure quarterly licensed health professional support (LHPS) evaluations were completed for 1 of 3 sampled residents with LHPS tasks for fingerstick blood sugar (FSBS) (#1). The findings are: Review of Resident #1's current FL-2 dated 12/12/21 revealed: -Diagnoses included diabetes mellitus, schizophrenia, obsessive compulsive disorder, hyperlipidemia, hypertension, and hepatitis C -There was no order for FSBS. -There was a medication order for Novolog flex pen 20 units before breakfast and dinner. -There was a medication order for Novolog flex pen 15 units at lunch. Observation of Resident #1 on 04/13/21 at 12:00pm revealed he received Novolog insulin 15units prior to the lunch meal service. Review of Resident #1's record revealed there were no licensed health professional support (LHPS) evaluations. Review of Resident #1's February, March and April 2021 medication administration records (MARs) revealed there was an entry for check FSBS twice daily, scheduled for 8:00am and	C 252		

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C 252	Continued From page 12 8:00pm. Interview with Resident #1 on 04/13/21 at 3:52pm revealed he had a FSBS twice daily. Interview with Administer on 04/13/21 at 4:06pm revealed: -Resident #1 was diagnosed with diabetes and he obtained a FSBS twice daily from Resident #1. -Resident #1 was administered insulin three times per day. -He did not currently have a LHPS nurse to complete the LHPS evaluations for residents. -He knew LHPS evaluations were supposed to be completed quarterly for residents with LHPS tasks. -He was responsible for ensuring the LHPS evaluations were completed for residents.	C 252		
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: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents related to a medication used to treat iron deficiency and a	C 330	With reference to 10A NCAC 13G .1004(a) Medication Administration, this deficiency has been corrected and orders obtained from physicians and documented. The administrator will ensure periodic review of resident records after every visit or appointment to update resident records.	5/7/21

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C 330	Continued From page 13 vitamin supplement (#2). The findings are: 1. Review of Resident #2's current FL-2 dated 04/10/21 revealed: -Diagnoses included congestive heart failure, atrial fibrillation, chronic leg ulcer, hypertension, and hyperlipidemia. a. Review of Resident #2's current FL-2 dated 04/10/21 revealed there was a medication order for ferrous sulfate 325 mg (used to treat or prevent low level of iron) twice daily. Review of Resident #2's February 2021 medication administration record (MAR) revealed: -There was an entry for ferrous sulfate 325mg every other day, scheduled for 8:00am. -There was documentation of administration of ferrous sulfate every other day from 02/01/21 to 02/28/21 at 8:00am. Review of Resident #2's March 2021 printed MAR revealed: -There was an entry for ferrous sulfate 325mg every other day, scheduled for 8:00am. -There was documentation of administration of ferrous sulfate every other day from 03/01/21 to 03/31/21 at 8:00am. Review of Resident #2's April 2021 printed MAR revealed: -There was an entry for ferrous sulfate 325mg every other day, scheduled for 8:00am. -There was documentation of administration of ferrous sulfate every other day from 04/01/21 to 04/13/21 at 8:00am. Observation of Resident #2's medications on	C 330	With reference to 10A NCAC 13G .1004(a) Medication Administration, all deficiencies have been corrected. Medication filled and administered as prescribed by the Resident Physician. And also FL-2	5/7/21

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C 330	Continued From page 14 hand on 04/13/21 at 12:15pm revealed: -There were 18 tablets remaining in a bubble pack for ferrous sulfate 325mg dispensed on 02/19/21. -There were 45 tablets dispensed and the medication label indicated take one tablet every other day. Telephone interview with Resident #2's facility contracted pharmacy on 04/13/21 at 12:44pm revealed: Telephone interview with a nurse at Resident #2's primary care provider (PCP) on 04/13/21 at 2:02pm revealed: -Resident #2 last saw his PCP on 04/21/21. -Resident #2 had an order for ferrous sulfate 325mg twice daily. -She thought the PCP ordered ferrous sulfate for Resident #2 because his iron was deficient. Interview with the Administrator on 04/13/21 at 4:15pm revealed: -He reviewed residents' FL-2s and ensured the medications were on the MARs. -He gave Resident #2 ferrous sulfate every other day. -He did not know Resident #2's current FL-2 had a different order for ferrous sulfate. -He thought the PCP had an old order that was used to place on the current FL-2. Refer to interview with the Administrator on 04/13/21 at 4:15pm. b. Review of Resident #2's current FL-2 dated 04/10/21 revealed there was a medication order for thiamine 100mg (used to treat low levels of vitamin B1) daily.	C 330	With reference to 10A NCAC 13G .1004(a) Medication Administration, all deficiencies have been corrected. Medication filled and administered as prescribed by the Resident Physician. And also FL-2	5/7/21

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C 330	Continued From page 15 Review of Resident #2's February 2021 medication administration record (MAR) revealed: -There was an entry for thiamine 100mg daily, scheduled for 8:00am. -There was documentation of administration of thiamine 100mg from 02/01/21 to 02/28/21 at 8:00am. Review of Resident #2's March 2021 printed MAR revealed: -There was an entry for thiamine 100mg daily, scheduled for 8:00am. -There was documentation of administration of thiamine 100mg from 03/01/21 to 03/31/21 at 8:00am. Review of Resident #2's April 2021 printed MAR revealed: -There was an entry for thiamine 100mg daily, scheduled for 8:00am. -There was documentation of administration of thiamine 100mg from 04/01/21 to 04/13/21 at 8:00am. Observation of Resident #2's medications on hand on 04/13/21 at 12:15pm revealed there was no thiamine 100mg available to administer. Interview with Resident #2 on 04/13/21 at revealed he did not recall the doctor ordering Thiamine, and he did not recall refusing Thiamine. Telephone interview with Resident #2's facility contracted pharmacy on 04/13/21 at 2:44pm revealed: -He had an active order for thiamine 100mg, and it was last dispensed 04/2020. -There were 100 tablets dispensed at that time. -The Administrator told the pharmacy that the	C 330	The administrator will ensure that the pharmacy supplies medications as been ordered by Resident PCP and also ensure that such medication has been administered by the facility as ordered to	

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C 330	Continued From page 16 resident refused the Thiamine. Telephone interview with a nurse at Resident #1's primary care provider (PCP) on 04/13/21 at 2:02pm revealed: -Resident #2 had an order for thiamine 100mg daily and it was listed as a "recorded" medication. -A "recorded" medication meant that the resident was on the medication prior to the PCP assuming care of the resident. Interview with the Administrator on 04/13/21 at 4:15pm revealed: -He thought Resident #2's Thiamine was discontinued but, he did not have a discontinue order for it. -He thought the discontinue order was given verbally to the pharmacy. -He had not administered Thiamine to Resident #2 and he did not notice that Thiamine was on Resident #2's current FL-2. 2. Review of Resident #1's current FL-2 dated 02/26/21 revealed: -Diagnoses included type 2 diabetes mellitus with neuropathy, bipolar mixed, smoker, and hyperlipidemia. -There was a medication order for Latuda "?0"mg (used to treat certain mood/mental health conditions) one daily. Review of Resident #1's February and March 2021 medication administration record (MAR) revealed: -There was an entry for Latuda 60 mg daily, scheduled for 6:00pm. -There was documentation of administration of Latuda 60mg from 02/01/21 to 03/31/21 at 6:00pm.	C 330	All deficiencies have been corrected. FL-2 and MAR have been corrected as been prescribed by the Resident PCP. Information in Resident Record.	5/12/21

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C 330	Continued From page 17 Review of Resident #1's April 2021 MAR revealed there was an entry for Latuda 60mg daily, scheduled for 6:00pm and there was documentation beside the entry that it was discontinued. Observation of Resident #1's medications on hand on 04/13/21 at 12:41pm revealed: -There was one bottle of Latuda 60mg with 19 tablets remaining dispensed on 03/12/21. -The medication label indicated the prescription was written on 01/06/21 by the resident's primary care provider (PCP). Telephone interview with Resident #1's pharmacist on 04/13/21 at 2:30pm revealed: -Resident #1 had an order dated 01/06/21 for Latuda 60mg take one tablet at bedtime. -There were 30 tablets dispensed on 03/12/21 and this was a 30 day supply. -The facility was on cycle fill and another delivery would be sent on 04/15/21. Interview with the Administrator on 04/13/21 at 3:45pm revealed: -The pharmacy provided MARs for the facility. -He received the MARs prior to the end of the month and placed them in the MAR book when he was ready to use them. -He reviewed the new MARs by comparing them to the previous months MARs. -He knew that Resident #1 had an order for Latuda. -He marked through the entry for Latuda by mistake on Resident #1's April MARs. -He had not documented administration of Latuda until 04/13/21, but he had administered Latuda to Resident #1. Refer to interview with the Administrator on	C 330	All deficiencies have been corrected. The administrator will periodically review MAR, FL-2 to ensure that medications are being administered as prescribed by resident PCP.	5/12/21

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C 330	Continued From page 18 04/13/21 at 4:15pm. Interview with the Administrator on 04/13/21 at 4:15pm revealed he was responsible for ensuring medications were administered as ordered by the PCP.	C 330		
C 350	10A NCAC 13G .1005 (a) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 3	C 350	With reference to 10A NCAC 13G .1005 (a) Self-Administration Of Medications has been corrected and has been filed in Resident Record. The administrator will ensure that all self administered medications have an order from resident PCP and will be in Resident Record. The administrator will notify the physician when there is a change in Resident mental or physical ability to administer or resident noncompliance with the physician's orders. The resident's physician has provided a self administration order and the order was placed in his record. 5/18/21-SS amended	5/12/21

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C 350	Continued From page 19 sampled residents (#2) who self-administered medications had orders to self-administer prescribed medications that were kept in the resident's room including a medicated lotion, moisturizing ointment, and a steroidal cream. The findings are: Review of Resident #2's current FL-2 dated 04/10/21 revealed congestive heart failure, atrial fibrillation, chronic leg ulcer, hypertension, and hyperlipidemia. -There was a medication order for Sarna lotion topical application daily as needed. -There was no documentation for the reason for the use of Sarna lotion. -There was no order for Aquaphor healing ointment. -There was no order for triamcinolone 0.1% ointment. Observation of Resident #2's medications in the resident's room on 04/13/21 at 9:35am revealed: -There was a bottle of Sarna lotion on Resident #2's bedside table and the medication label indicated it was dispensed on 10/05/20. -There was an empty jar of Aquaphor on Resident #2's bedside table without a medication label. -There was a jar of triamcinolone 0.1% ointment on Resident #2's bedside table. -The topical medications were not ordered by Resident #2's PCP. Telephone interview with Resident #2's primary care provider on 04/13/21 at 2:02pm revealed: -Sarna lotion, triamcinolone and Aquaphor ointment were not listed as active medications for Resident #2. -She did not have any documentation that Resident #2 could self-administer any	C 350	The administrator will ensure that all self administered medication is monitored and documented in resident record.	

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C 350	Continued From page 20 medications. Telephone interview with Resident #2's pharmacist on 04/13/21 at 2:30pm revealed: -There was no self-administration note in the computer system for Resident #2's Sarna lotion, Aquaphor, and triamcinolone ointment. -There was an order for Sarna lotion dated 04/07/20 and it was last dispensed on 10/05/20. -There was an order for Aquaphor ointment dated 04/07/20 and it was never dispensed to the facility. -Aquaphor ointment was an over the counter and the facility might have purchased it. -There was an order for triamcinolone 0.1% ointment dated 05/22/20 and it was dispensed on 10/06/20 Interview with Resident #2 on 04/13/21 at 1:15pm revealed: -He applied the Sarna lotion for itching. -He used the Aquaphor as needed because it was the same the triamcinolone ointment and he was told that by his PCP. -He applied the triamcinolone all over his body every other day. -He was seen at a local wound clinic every two weeks for a una boot change on his legs. Interview with the Administrator/medication aide (MA) on 04/13/21 at 4:30pm revealed: -Resident #2 insisted on applying topical medications himself, so he let him keep the medications. -He did not obtain a self-administration medication order for Resident #2, but should have obtained an order. -He was responsible for ensuring a PCP order was obtained for self-administration of medication by a resident.	C 350	The administrator will ensure that non-self administered medication will not be in the Resident's room and all self medication must have an order, monitored and documented by the facility.	

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(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 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to the screening of residents, staff and visitors. The findings are:	C 612	With reference to 10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp), deficiency has been corrected. The administrator will ensure that the facility has implemented the infection prevention and control program as directed by the CDC, NCDHHS or local health department.	5/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091017	A. BUILDING: _____ B. WING _____	R 04/13/2021

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C 612	Continued From page 22 Review of the Centers for Disease Control and Prevention (CDC) Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities dated 03/20/21 revealed designate one or more facility employees to ensure all residents and staff have been screened at least daily for symptoms consistent with COVID-19 (fever or chills, cough, shortness of breath or difficulty of breathing, fatigue, headache, body aches, loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. Review of the NC Department of Health and Human Services COVID-19 Long Term Care (LTC) Infection Control Assessment and Response Tool for LHD dated 10/2020 revealed staff and residents should be screened daily for fever, signs and symptoms of COVID-19. Review of the facility's infection control policy revealed: -There was no date on the policy. -There were instructions for when to use gloves, masks, gowns, and eye protection. -There were instructions for hand washing and universal precautions. Based on record reviews and interviews the facility did not have a COVID-19 policy. Observation of the facility on 04/13/21 at 9:09am revealed: -A resident came to the front door and called for the facility's staff who was upstairs. -Staff came downstairs to the front entrance door of the facility wearing a face mask and stated there was nothing that needed to be done prior to entrance into the facility.	C 612	All deficiencies have been corrected. The administrator will ensure that all Infection control/COVID-19 Guidelines by the facility.	5/12/21

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C 612	Continued From page 23 Observation of the facility on 04/13/21 at 9:30am revealed: -A resident's family member came into the facility to visit wearing a face mask but staff did not check her temperature. -Staff did not ask any questions concerning COVID-19 symptoms. Observation of the facility on 04/13/21 at 5:00pm revealed a repairman entered the facility and the Administrator did not take his temperature nor did he ask any questions concerning COVID-19 symptoms. Observation of the facility on 04/13/21 at 5:20pm revealed there was an infrared thermometer available for use in the facility. Based on record reviews and interviews, the facility did not have any staff, visitor or resident screening logs for COVID-19 screening. Interview with a resident on 04/13/21 at 9:49am revealed his temperature was checked at the physician's office. Interview with another resident on 04/13/21 at 10:39am revealed the Administrator had never checked his temperature at the facility. Interview with the Administrator on 04/13/21 at 5:05pm revealed: -He and his family member were the only staff and lived in the facility. -He went out to the grocery store and to attend resident's physician's appointments. -He took his temperatures daily, but he did not document it anywhere -He did not have a screening log for visitors or staff to document if they had any symptoms of	C 612	The administrator will ensure that all staff and patient in the facility temperatures are checked daily and documented The administrator will also ensure that the facility keeps The temperature log sheet Screening log sheet for visitors All symptoms are documented and reported to the appropriate authority, CDC, NCDHHS or LHD registered nurse.	

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C 612	Continued From page 24 COVID-19. -He did check the residents' temperatures daily but, did not document any residents' temperatures on their MARs. -He had received the COVID-19 vaccine, and the residents received the vaccine. -He did not know the CDC guidelines concerning screening of residents, staff or visitors. -He had received emails from NC DHHS and the local health department concerning COVID-19. -He was responsible for ensuring all staff were following the guidelines of the CDC and LHD for infection control by providing daily temperature screenings for residents and staff in the facility. Attempted telephone interview with the local county health department (LHD) Registered Nurse (RN) on 04/13/21 at 5:33pm was unsuccessful.	C 612	The administrator will ensure the Resident and Staff temperature is checked daily and documented	