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 _____	09/20/2022

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 September 20, 2022.	C 000	With reference to your annual and follow up survey on 20th Sept 2022	
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 2 of 3 sampled residents (#2 and #3) had completed tuberculosis (TB) testing in compliance with the control measures for the Commission for Health Services. The findings are: 1. Review of Resident #2's current FL-2 dated 11/19/21 revealed diagnoses included affective psychosis, paranoid schizophrenia, hypertension, obesity, depression, hypothyroidism, alcohol use disorder, and hyperlipidemia. Review of Resident #2's tuberculosis (TB) skin test revealed: -There was documentation of a TB skin test administered on 09/01/21 and read as negative	C 202	Upon admission, employment, or living staff in a family care home, all shall be tested for tuberculosis. 1st & 2nd step in compliance with control measures adopted by the Commission to Public Health as specified in 10A NCAC has been completed on 09/26/22. Copies from Bedford Med. Center attached. The Administrator will periodically monitor to ensure that all residents and staff are tested.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maurice Achu

TITLE: Administrator

(X6) DATE: 11/07/22

Reviewed and acknowledged- SS- 11/07/22

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 _____	09/20/2022

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 202	Continued From page 1 on 09/03/21. -There was no documentation of a second TB skin test. Interview with Resident #2 on 09/20/22 at 3:40pm revealed: -He had a TB skin test completed at his Primary Care Provider's (PCP) office prior to his admission to the facility in 2021. -He thought the TB skin test was negative. -He had not had another TB skin test since his admission. Interview with the Administrator/medication aide (MA) on 09/20/22 at 4:27pm revealed: -He thought Resident #2 had a TB skin test upon admission. -He had not taken Resident #2's to obtain a second TB skin test. Refer to the interview with the Administrator/MA on 09/20/22 at 4:27pm. 2. Review of Resident #3's current FL-2 dated 05/07/22 revealed diagnoses included schizophrenia and alcohol abuse. Review of Resident #3's tuberculosis (TB) skin test revealed: -There was documentation of a TB skin test administered on 06/09/20 and read as negative on 06/11/20. -There was no documentation of a second TB skin test. Interview with Resident #3 on 09/20/22 at 3:33pm revealed: -He thought he had completed a TB skin test, but he did not remember the dates. -He did not know the results of the TB skin test.	C 202	Resident number 2 and 3 TB test has been completed on 09/26/22. See attached copies.	

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 _____	09/20/2022

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 202	Continued From page 2 Interview with the Administrator/MA on 09/20/22 at 4:27pm revealed: -He thought Resident #3 had received all the required TB skin test. -He did not know Resident #3 did not have documentation of a second TB skin test. Refer to the interview with the Administrator/MA on 09/20/22 at 4:27pm. _____ Interview with the Administrator/MA on 09/20/22 at 4:27pm revealed he was responsible for ensuring residents had a completed TB skin test upon admission to the facility.	C 202		
C 207	10A NCAC 13G .0702(c)(4) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (c) The results of the complete examination are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the administrator or supervisor-in-charge shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the FL-2s for 3 of 3 sampled residents (#1) included a diet order.	C 207	With ref. to 20710A NCAC 13G 0702 TB skin test must be done upon a new admission. The administrator will monitor FL-2 and MAR to ensure that all information are implemented according to Medicaid Program for Mental Retardation. The administrator must periodically ensure and monitor all information in the FL-2 or MAR. For orders that is not clear, the administrator should contact the patient physician for clarification. The administrator will ensure and monitor that FL2 and diet order is clearly indicated to meet resident need.	

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 _____	09/20/2022

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 207	Continued From page 3 The findings are: 1. Review of Resident #1's current FL-2 dated 12/08/21 revealed: -Diagnoses included schizophrenia, hypertension, hypothyroidism, benign prostatic hyperplasia (BPH), hyperlipidemia, and type 2 diabetes mellitus. -There was no diet order. Review of Resident #1's subsequent physician orders revealed there were no diet orders in the record. Interview with a Supervisor in Charge (SIC) on 09/20/22 at 8:40am revealed she did not know what the Primary Care Provider (PCP) ordered for Resident #1's diet order. Interview with the Administrator on 09/20/22 at 4:27pm revealed: -He was responsible for the FL-2s and he did not know there was no diet order on Resident #1's FL-2. -This was an oversight on his part. -He recalled Resident #1 was admitted to the facility on a regular diet. Based on observations, record reviews, and interview it was determined that Resident #1 was not interviewable. Attempted telephone interview with Resident #1's PCP on 09/20/22 at 2:55pm. Refer to the interview with the Supervisor in Charge (SIC) on 09/20/22 at 8:40am. Refer to the interview with the Administrator on 09/20/22 at 4:27pm.	C 207	Any uncleared order, the administrator will contact the Resident Physician. FL-2 corrected and diet order corrected on 10/21/22 to meet resident care plan.	

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 _____	09/20/2022

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 207	Continued From page 4 2. Review of Resident #2's current FL-2 dated 11/19/21 revealed: -Diagnoses included affective psychosis, paranoid schizophrenia, hypertension, obesity, depression, hypothyroidism, alcohol use disorder, and hyperlipidemia. -There was no diet order. Review of Resident #2's subsequent physician orders revealed there was a no added salt/regular diet on a previous FL-2 dated 07/26/21 in the record. Interview with Resident #2 on 09/20/22 at 3:40pm revealed: -He did not have any diet restrictions. -He could eat anything he wanted. Interview with the Administrator on 09/20/22 at 4:27pm revealed: -He thought Resident #2 had a regular diet. -He did not know that Resident #2 did not have a diet order on his current FL-2. Attempted telephone interview with Resident #2's PCP on 09/20/22 at 2:45pm. Refer to the interview with the Supervisor in Charge (SIC) on 09/20/22 at 8:40am. Refer to the interview with the Administrator on 09/20/22 at 4:27pm. 3. Review of Resident #3's current FL-2 dated 05/07/22 revealed: -Diagnoses included schizophrenia and alcohol abuse. -There was no diet order.	C 207	Continued on C207 A new FL-2 for resident #2 has been completed on 10/21/22. The administrator will monitor and review FL-2 every six months or periodically to ensure that deficiencies do not occur again. Resident #2 diet order completed on 10/21/22.	

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 _____	09/20/2022

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 207	Continued From page 5 Review of Resident #3's subsequent physician orders revealed there were no diet orders in the record. Interview with Resident #3 on 09/20/22 at 3:33pm revealed he did not have a special diet. Attempted telephone interview with Resident #3's PCP on 09/20/22 at 2:55pm. Refer to the interview with the Supervisor in Charge (SIC) on 09/20/22 at 8:40am. Refer to the interview with the Administrator on 09/20/22 at 4:27pm. _____ Interview with the Supervisor in Charge (SIC) on 09/20/22 at 8:40am revealed: -She had worked at the facility since 09/04/22 and she was trained by the Administrator. -She served all residents a regular diet and did not add salt to the foods she prepared. Interview with the Administrator on 09/20/22 at 4:27pm revealed: -He was responsible for the FL-2s. -He reviewed the FL-2's after the physician signed it and looked to ensure all the medication orders were on the form. -He thought the residents had a FL-2 that contained all the necessary orders and information. -The diet orders that were missing from the residents' FL-2s were oversights on his part.	C 207		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of	C 231	With ref. to C 231 10A NCAC 13G 0801 Resident assessment the administrator shall ensure it is done every year to assure resident proper care. Assessment completed on 10/21/22.	

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 _____	09/20/2022

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 231	Continued From page 6 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, 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 12/08/21 revealed diagnoses included schizophrenia, hypertension, hypothyroidism, benign prostatic hyperplasia (BPH), hyperlipidemia, and type 2 diabetes mellitus. Review of Resident #1's record revealed there was no care plan.	C 231	With ref. to C 231 the initial assessment is done within 72 hours upon new admission or thereafter annually. The administrator will monitor and ensure that the facility completes an assessment of each resident within 30 days annually thereafter. All 3 of the resident's care plan and assessment has been completed on 10/21/22 The administrator will monitor and review their file periodically to ensure that this deficiency does not occur again	

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 _____	09/20/2022

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 231	Continued From page 7 Based on observations, record reviews, and interview it was determined that Resident #1 was not interviewable. Refer to the interview with the Administrator on 09/20/22 at 4:27pm. 2. Review of Resident #2's current FL-2 dated 11/19/21 revealed diagnoses included affective psychosis, paranoid schizophrenia, hypertension, obesity, depression, hypothyroidism, alcohol use disorder, and hyperlipidemia. Review of Resident #2's record revealed: -There was a care plan dated 07/22/21 not signed by Resident #2's Primary Care Provider (PCP). -There was no current care plan signed by Resident #2's PCP. Interview with Resident #2 on 09/20/22 at 3:40pm revealed: -He was admitted from the hospital over a year ago. -He did his own laundry and had an assigned day to do laundry. -Staff provided him with meals and administered his medications. -He walked to the local store and was independent with regard to activities of daily living (ADL). Refer to the interview with the Administrator on 09/20/22 at 4:27pm. 3. Review of Resident #3's current FL-2 dated 05/07/22 revealed: -Diagnoses included schizophrenia and alcohol abuse. -There was no diet order.	C 231		

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 _____	09/20/2022

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 231	Continued From page 8 Review of Resident #3's record revealed: -There was no current care plan. -There was a previous care plan dated 04/15/21 signed by Resident #3's Primary Care Provider (PCP) on 05/12/21. Interview with Resident #3 on 09/20/22 at 3:33pm 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 the interview with the Administrator on 09/20/22 at 4:27pm. _____ Interview with the Administrator on 09/20/22 at 4:27pm 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 was responsible for ensuring resident care plans were updated annually and the physician signed the care plans.	C 231	Continued from page 8, C 231. Resident #2 and #3's care plan and assessment has been completed on 10/21/22. The administrator will monitor periodically to ensure that this deficiency does not occur again.	
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date	C 254	With ref. to C 254 10A NCAC 13G, the LHPS completed on 10/12/22. The administrator has engaged a registered nurse to be doing the licensed healthcare professional assessment quarterly or within 30 days of new admission. The administrator will quarterly monitor this rule 10A NCAC to make sure deficiency does not occur again.	

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 _____	09/20/2022

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 254	Continued From page 9 a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule 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 1 sampled resident with LHPS tasks for fingerstick blood sugar (FSBS) (#1). The findings are: Review of Resident #1's current FL-2 dated 12/08/21 revealed: -Diagnoses included schizophrenia, hypertension, hypothyroidism, benign prostatic hyperplasia (BPH), hyperlipidemia, and type 2 diabetes mellitus. -There was no order for FSBS. -There was a medication order for Levemir flex pen 10 units in the morning and 5 units in the evening. -There was a medication order for glipizide 5mg one tablet twice daily. -There was a medication order for metformin 850mg one tablet twice daily.	C 254	Cont on C 254 LHPS completed on 10/12/22. The administrator will monitor quarterly to ensure deficiency does not occur again.	

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 _____	09/20/2022

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 254	Continued From page 10 Observation of Resident #1's medications on hand on 09/20/22 at 12:40pm revealed he had a glucometer and 5 flex pens of Levemir. Review of Resident #1's record revealed: -There were licensed health professional support (LHPS) evaluations dated 11/02/21 and 02/02/22. -There were no LHPS evaluations for May 2022 and August 2022. Review of Resident #1's July, August, and September 2022 medication administration records (MARs) revealed there was an entry for check FSBS daily, scheduled for 8:00am. Interview with Administer on 09/20/22 at 4:27pm revealed: -Resident #1 was diagnosed with diabetes and he obtained a FSBS daily from Resident #1. -Resident #1 was administered insulin twice daily. -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. Based on observations, record reviews, and interview it was determined that Resident #1 was not interviewable.	C 254	Rising Hope Healthcare Services has permanently engaged licensed healthcare professional support/a registered nurse. The administrator will monitor quarterly to ensure that this deficiency does not occur again.	
C 266	10A NCAC 13G .0904 (c-3) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (3) Any substitutions made in the menu shall be	C 266	With ref. to C 266 10A NCAC 13G 0904 (C-3) Nutrition and food services. A substitute menu sheet has been developed on 09/21/22 to meet resident standard feeding according to the menu. The administrator will ensure that this deficiency will not occur again.	

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 _____	09/20/2022

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 266	Continued From page 11 of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure substitutions made on the menu were documented to indicate the foods served to residents. The findings are: Review of the facility's no concentrated sweets/no added salt diet lunch menu for Tuesday revealed: -The menu was not dated and indicated it was cycle 1. -Residents were to be served a turkey sandwich, ½ cup of potato salad, ½ cup of beets, a roll, ½ cup of unsweetened pears, 1 cup of tea and 1 cup of water. Observation of the lunch meal service on 09/20/22 at 12:30pm revealed: -The residents were served a turkey sandwich with mayonnaise, potato salad, a snack bag of chips, beets, and an 8-ounce glass of orange juice. -There was no fruit served to the residents. Interview with the Supervisor in Charge (SIC) on 09/20/22 at 9:18am revealed: -She was told to use the menu that was hanging on the wall in the kitchen. -She usually had the items listed on the menu. -She did not document when she served something different than what was listed on the menu. -No one told her she was supposed to document menu substitutions.	C 266	Ref to C 266, the administrator will ensure that the facility must serve what is in the menu and any substitute made must be documented and substitute must be of equal nutritional value.	

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 _____	09/20/2022

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 266	Continued From page 12 -She substituted food group for food group. Interview with the Administrator on 09/20/22 at 4:36pm revealed: -Staff were supposed to use the menus to prepare meals for the residents. -He had not given staff any direction on how to do substitutions. -He did not document substituting chips for a roll during the lunch meal service. -He did not document substituting orange juice for tea for the lunch meal service -He did not know he needed to document menu substitutions. -He was responsible for ensuring menu substitutions were documented.	C 266	Cont. C 266 Substitute sheet completed on 09/21/22	
C 320	10A NCAC 13G .1002 (f) Medication Orders 10A NCAC 13G .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration, are reviewed and signed by the resident's physician or prescribing practitioner at least every six months This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure all current orders for medications or treatments were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 2 of 3 sampled residents (#1 and #2). The findings are: 1. Review of Resident #1's current FL-2 dated	C 320	All orders has been signed on 10/26/22. With ref to C 320 10A NCAC 13G 1002 med orders the administrator shall ensure that all orders and self-administered orders must be signed and kept in file. The administrator will monitor and ensure that all self-administered is signed to ensure deficiency does not occur.	

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 _____	09/20/2022

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 320	Continued From page 13 12/08/21 revealed: -Diagnoses included schizophrenia, hypertension, hypothyroidism, benign prostatic hyperplasia (BPH), hyperlipidemia, and type 2 diabetes mellitus. -There was an order for levothyroxine 150mcg (used to treat an underactive thyroid) daily. -There was an order for lisinopril 10mg (used to treat high blood pressure) take one tablet daily. -There was an order for glipizide (used to control high blood sugar) 5mg take one tablet twice daily. -There was an order for risperidone (used to treat schizophrenia) 3mg take one tablet twice daily. -There was an order for metformin (used to control high blood sugar) 850mg twice daily. -There was an order for simvastatin (used to lower high lipids) 20mg one tablet daily. -There was an order for tamsulosin (used to treat the symptoms of an enlarged prostate) 0.4mg one tablet daily. -There was an order for spironolactone (used to treat high blood pressure) 25mg one tablet twice daily. -There was an order for docusate sodium (used to treat constipation) 100mg one tablet twice daily. -There was an order for trazodone (used to treat insomnia) 50mg one tablet at bedtime. -There was an order for Levemir flextouch (used to treat high blood sugar) 10 units in the morning and 5 units in the evening. Review of Resident #1's record revealed there were no signed six-month physician orders after the current FL-2 dated 12/18/21. Refer to the interview with the Administrator on 09/20/22 at 4:36pm. 2. Review of Resident #2's current FL-2 dated	C 320	The administrator has been reassured that every six months all FL-2 and MAR will be reviewed and signed by the the resident physician. An information board has been created in the facility as a reminder to the administrator and SIC when such is due to prevent future deficiency.	

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 _____	09/20/2022

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 320	Continued From page 14 11/19/21 revealed: -Diagnoses included affective psychosis, paranoid schizophrenia, hypertension, obesity, depression, hypothyroidism, alcohol use disorder, and hyperlipidemia. -There was an order for folic acid (used to treat folate deficiency) 1mg one tablet daily. -There was an order for thiamine 100mg (used to treat low levels of vitamin B1) take one tablet daily. -There was an order for cyanocobalamin (used to treat vitamin B12 deficiency) 1,000mcg one tablet daily. -There was an order for levothyroxine 50mcg (used to treat an underactive thyroid) daily. -There was an order for levetiracetam (used to treat seizures) 500mg one tablet twice daily. -There was an order for trazodone (used to treat depression and insomnia) 200mg take one tablet every evening. -There was an order for paliperidone (used to treat certain mental/mood disorders) 150mg one capsule daily. -There was an order for metoprolol (used to treat hypertension) 12.5mg take one tablet twice daily. -There was an order for risperidone (used to treat schizophrenia) 3mg take one tablet twice daily. -There was an order for acamprosate (used to help support with alcohol dependence) 333mg one tablet three times daily. -There was an order for amlodipine (used to treat hypertension) 10mg one tablet daily. -There was an order for atorvastatin (used to lower high lipids) 20mg one tablet daily. -There was an order for omeprazole (used to treat gastro-esophageal reflux disease) 20mg every morning. -There was an order for sertraline (used to treat depression) 50mg daily. -There was an order for melatonin (used to treat	C 320	Continued on C 320. Resident # 2 FL-2 updated on 10/21/22. The administrator will monitor FL-2 to ensure that physician reviewed and signed to ensure that deficiency does not occur again.	

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 _____	09/20/2022

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 320	Continued From page 15 insomnia) 3mg every evening. -There was an order for hydroxyzine (used to treat itching) 25mg every 8 hours as needed. Review of Resident #2's record revealed there were no signed six-month physician orders after the current FL-2 dated 11/19/21. Refer to the interview with the Administrator on 09/20/22 at 4:36pm. Telephone interview with the Administrator on 09/20/22 at 4:36pm revealed: -He did not know what six-month physician orders were. -He did not know the current orders for the resident's medications should be signed by the physician every six months. -He had not requested the residents' physician to review a current medication order list for the residents and had it signed by the resident's primary care providers (PCP).	C 320	The administrator, with the help of the physician and reminder information board in the facility FL-2 and MAR must be reviewed every six months and signed by the resident physician (PCP). The administrator will ensure that deficiency does not occur again	
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	C 330	With ref. C 330 10A NCAC 13G 1004 Med. administration The administrator will at all times monitor physician orders to make sure the orders are maintained in the facility in accordance to the resident physician (PCP) to ensure that deficiency does not occur again.	

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 _____	09/20/2022

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 330	Continued From page 16 interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents related to medications used to treat fungal infections (#1), three vitamin supplements, a sleep aid, a medication used to treat benign prostate hyperplasia, and an electrolyte replacement (#2). The findings are: 1. Review of Resident #1's current FL-2 dated 12/08/21 revealed diagnoses included schizophrenia, hypertension, hypothyroidism, benign prostatic hyperplasia (BPH), hyperlipidemia, and type 2 diabetes mellitus. Review of Resident #1's Primary Care Provider's (PCP) orders revealed: -There was an order dated 08/04/22 for terbinafine 250mg (used to treat fungal infections) one tablet daily. -There was a note dated 08/04/22 to not dispense terbinafine until lab was obtained on patient. Review of Resident #1's August 2022 printed medication administration record (MAR) revealed there was no entry for terbinafine 250mg and there was no documentation of administration of terbinafine. Review of Resident #1's MAR 09/01/22-09/20/22 revealed: -There was an entry for terbinafine 250mg one tablet one tablet daily, scheduled for 8:00am. -Terbinafine 250mg was documented as administered from 09/01/22 to 09/20/22 at 8:00am. Observation of Resident #1's medications on hand on 09/20/22 at 12:40pm revealed there was	C 330	Cont. from C 330 the administrator has ensured that all physician orders must be carried out in accordance to orders in the FL-2 according to resident physician	

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 _____	09/20/2022

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 330	Continued From page 17 no terbinafine available to administer. Telephone interview with Resident #1's facility contracted pharmacy on 09/20/22 at 2:20pm revealed: -Resident #1 had an order dated 08/04/22 for terbinafine 250mg one tablet daily. -Resident #1's Primary Care Provider (PCP) sent a note with the order to not dispense the medication until labs were obtained for Resident #1. -Resident #1's PCP had not contacted the pharmacy to dispense terbinafine. Interview with the Supervisor in Charge (SIC) on 09/20/22 at 3:51pm revealed: -She did not realize she was signing for a medication that was not available to administer. -She looked for Resident #1's terbinafine and she did not see it in the medication cart. -She thought that she confused Resident #1's terbinafine with another medication whose name began with the letter "t". Interview with the Administrator on 09/20/22 at 4:40pm revealed: -He reviewed residents' FL-2s and ensured the medications were on the MARs. -He did not know Resident #1 had an order for terbinafine. -He did not add terbinafine to Resident #1's August 2022 MAR. -He did not have the order for terbinafine in Resident #1's record and he had to obtain it from the pharmacy. -He did not know the reason Resident #1 did not have terbinafine dispensed to the facility. -He did not know the reason the SIC documented administering terbinafine when it was not dispensed to the facility.	C 330	Cont. 330 from page 17 the administrator will ensure the SIC on duty will ensure that any medication dispense signed will match with MAR/FL-2 in the facility	

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 _____	09/20/2022

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 330	Continued From page 18 Based on observations, record reviews, and interview it was determined that Resident #1 was not interviewable. Attempted telephone interview with Resident #1's PCP on 09/20/22 at 2:55pm. Refer to interview with the Administrator on 09/20/22 at 4:40pm. 2. Review of Resident #2's current FL-2 dated 11/19/21 revealed diagnoses included affective psychosis, paranoid schizophrenia, hypertension, obesity, depression, hypothyroidism, alcohol use disorder, and hyperlipidemia. a. Review of Resident #2's current FL-2 dated 11/19/21 revealed there was a medication order for folic acid 1mg (used to treat folate deficiency) daily. Review of Resident #2's July 2022 printed medication administration record (MAR) revealed: -There was an entry for folic acid 1mg daily, scheduled for 8:00am. -There was documentation folic acid 1mg was administered from 07/01/22 to 07/31/22 at 8:00am. -There were no exception notes written on the MAR for folic acid. Review of Resident #2's August 2022 printed MAR revealed: -There was an entry for folic acid 1mg daily, scheduled for 8:00am. -There was documentation folic acid 1mg was administered from 08/01/22 to 08/31/22 at 8:00am. -There were no exception notes written on the	C 330	Cont on page 18 Reviewed Resident #2 current FL-2 dated 10/21/22, new FL-2 and MAR all medications are available and in the facility. The administrator will monitor and order medications earlier to allow time for mailing since it is coming from VA Pharmacy.	

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 _____	09/20/2022

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 330	Continued From page 19 MAR for folic acid. Review of Resident #2's printed MAR for 09/01/22-09/20/22 revealed: -There was an entry for folic acid 1mg daily, scheduled for 8:00am. -There was documentation folic acid 1mg was administered from 09/01/22 to 09/20/22 at 8:00am. -There were no exception notes written on the MAR for folic acid. Observation of Resident #2's medications on hand on 09/20/22 at 12:59pm revealed there was no folic acid available to administer to Resident #2. Review of Resident #2's pharmacy dispense records on hand revealed there was no record that folic acid was dispensed for Resident #2. Interview with Resident #2 on 09/20/22 at 3:40pm revealed he did not recall an order for folic acid and he was not able to identify a tablet of folic acid. Interview with the Supervisor of Charge (SIC) on 09/20/22 at 3:51pm revealed: -She did not know Resident #2's folic acid was not available to administer. -She documented administering Resident #2's folic acid in September 2022. -She needed to read the medication labels closely and the MAR. Interview with the Administrator on 09/20/22 at 4:40pm revealed: -He did not know Resident #2's had an order for folic acid. -He did not know there was no folic acid available	C 330	Cont on page 19 MAR and FL-2 reviewed and updated. Resident #2 medication folic acid available now in the facility . The administrator will read the medication label closely and the MAR to ensure that efficiency does not occur again.	

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 _____	09/20/2022

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 330	Continued From page 20 to administer to Resident #2. Attempted telephone interview with Resident #2's PCP on 09/20/22 at 2:45pm. Attempted telephone interview with Resident #2's pharmacy on 09/20/22 at 3:00pm. Refer to the interview with the Administrator on 09/20/22 at 4:40pm. b. Review of Resident #2's current FL-2 dated 11/19/21 revealed there was a medication order for thiamine 100mg (used to treat low levels of vitamin B1) daily. Review of Resident #2's July 2022 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 07/01/22 to 07/31/22 at 8:00am. Review of Resident #2's August 2022 printed MAR revealed: -There was an entry for thiamine 100mg daily, scheduled for 8:00am. -There was documentation of administration of thiamine 100mg from 08/01/22 to 08/31/22 at 8:00am. Review of Resident #2's printed MAR for 09/01/22-09/20/22 revealed: -There was an entry for thiamine 100mg daily, scheduled for 8:00am. -There was documentation of administration of thiamine 100mg from 09/01/22 to 09/20/22 at 8:00am.	C 330	Cont on C 330 FL-2 reviewed and updated on 10/21/22. The administrator will monitor the FL-2 and MAR to ensure the deficiency doesn't occur again.	

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 _____	09/20/2022

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 330	Continued From page 21 Observation of Resident #2's medications on hand on 09/20/22 at 12:59pm revealed there was a bottle of thiamine 100mg dispensed on 11/09/21 with approximately 50 of 100 tablets available to administer. Interview with Resident #2 on 09/20/22 at 3:40pm revealed he did not recall the doctor ordering Thiamine, and he was not able to identify a tablet of Thiamine. Interview with the Supervisor of Charge (SIC) on 09/20/22 at 3:51pm revealed: -She administered Thiamine to Resident #2 daily in the morning. -She did not know the reason there was still a bottle of Thiamine available from 11/09/21. -When she began working at the facility on 09/04/22, she used the bottle of Thiamine dispensed on 11/09/21. Interview with the Administrator on 09/20/22 at 4:40pm revealed: -Resident #2's Thiamine was dispensed by a government pharmacy. -He requested refills for Resident #2's medications via telephone. -Resident #2's medications were mailed to the facility. -He thought staff were giving Resident #2 Thiamine daily, but he did not know a reason a bottle dispensed in 11/09/21 was still in use. -He thought that staff were not reading the MAR and comparing the medications to the MAR. Attempted telephone interview with Resident #2's PCP on 09/20/22 at 2:45pm. Attempted telephone interview with Resident #2's pharmacy on 09/20/22 at 3:00pm.	C 330	Cont on page 21 Resident #2 MAR and FL-2 reviewed and updated. The administrator will periodically monitor and inspect FL-2, MAR, Physician orders to ensure that deficiency does not again.	

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 _____	09/20/2022

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 330	Continued From page 22 Refer to the interview with the Administrator on 09/20/22 at 4:40pm. c. Review of Resident #2's current FL-2 dated 11/19/21 revealed there was a medication order for melatonin 3mg (used to treat insomnia) at bedtime. Review of Resident #2's July 2022 medication administration record (MAR) revealed: -There was an entry for melatonin 5mg two tablets at bedtime, scheduled for 8:00pm. -There was documentation of administration of melatonin 5mg two tablets from 07/01/22 to 07/31/22 at 8:00pm. Review of Resident #2's August 2022 printed MAR revealed: -There was an entry for melatonin 5mg two tablets at bedtime, scheduled for 8:00pm. -There was documentation of administration of melatonin 5mg two tablets from 08/01/22 to 08/31/22 at 8:00pm. Review of Resident #2's printed MAR for 09/01/22-09/20/22 revealed: -There was an entry for melatonin 5mg two tablets at bedtime, scheduled for 8:00pm. -There was documentation of administration of melatonin 5mg two tablets from 09/01/22 to 09/19/22 at 8:00pm. Observation of Resident #2's medications on hand on 09/20/22 at 12:59pm revealed there was no melatonin available to administer. Interview with Resident #2 on 09/20/22 at 3:40pm revealed: -He took medication to help him sleep and he	C 330	Cont from page 22 Current and new FL-2 obtained on 10/21/22. And the administrator will continue to monitor FL-2 and MAR to ensure that deficiency does not occur again.	

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 _____	09/20/2022

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 330	Continued From page 23 thought it was melatonin. -He could not identify a tablet of melatonin if it was in his medication cup. Interview with the Supervisor of Charge (SIC) on 09/20/22 at 3:51pm revealed: -She did not know Resident #2's melatonin was not available to administer. -She documented administering Resident #2's melatonin in September 2022. -She needed to read the medication labels closely and the MAR. Interview with the Administrator on 09/20/22 at 4:40pm revealed: -He thought that he reordered Resident #2's melatonin. -He expected that it would arrive to the facility soon. -He had to begin reordering Resident #2's medications before all the medication was administered. Attempted telephone interview with Resident #2's PCP on 09/20/22 at 2:45pm. Attempted telephone interview with Resident #2's pharmacy on 09/20/22 at 3:00pm. Refer to the interview with the Administrator on 09/20/22 at 4:40pm. d. Based on record reviews, there was no order available for review for certavite senior anti-oxidant (used to prevent vitamin deficiency) in Resident #2's record. Review of Resident #2's July 2022 printed medication administration record (MAR) revealed: -There was an entry for certavite senior	C 330	Cont on page 23 Current FL-2 updated on 10/21/22. The administrator will monitor FL-2 and MAR to ensure that deficiency does not occur again.	

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 _____	09/20/2022

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 330	Continued From page 24 anti-oxidant one tablet daily, scheduled for 8:00am. -There was documentation was certavite senior anti-oxidant administered from 07/01/22 to 07/31/22 at 8:00am. -There were no exception notes written on the MAR for folic acid. Review of Resident #2's August 2022 printed MAR revealed: -There was an entry for certavite senior anti-oxidant daily, scheduled for 8:00am. -There was documentation certavite senior anti-oxidant was administered from 08/01/22 to 08/31/22 at 8:00am. -There were no exception notes written on the MAR for folic acid. Review of Resident #2's printed MAR for 09/01/22-09/20/22 revealed: -There was an entry for certavite senior anti-oxidant daily, scheduled for 8:00am. -There was documentation certavite senior anti-oxidant was administered from 09/01/22 to 09/20/22 at 8:00am. -There were no exception notes written on the MAR for folic acid. Observation of Resident #2's medications on hand on 09/20/22 at 12:59pm revealed there was no certavite senior anti-oxidant available to administer to Resident #2. Review of Resident #2's pharmacy dispense records on hand revealed there was no record of certavite senior anti-oxidant was dispensed for Resident #2. Interview with the Supervisor of Charge (SIC) on 09/20/22 at 3:51pm revealed:	C 330	Cont on page 24 Resident #2, all medication available now in the facility. The administrator will ensure that medication for #2 are ordered on time since medication is coming from VA Pharmacy by mail.	

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 _____	09/20/2022

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 330	Continued From page 25 -She had documented administering certavite senior anti-oxidant to Resident #2. -She thought she had administered certavite senior anti-oxidant to him but she could not locate the medication in the medication cart. -She thought she had not read Resident #2's MAR and medications closely. Interview with the Administrator on 09/20/22 at 4:40pm revealed he did not know there was no certavite senior anti-oxidant available to administer to Resident #2. Attempted telephone interview with Resident #2's PCP on 09/20/22 at 2:45pm. Attempted telephone interview with Resident #2's pharmacy on 09/20/22 at 3:00pm. Refer to the interview with the Administrator on 09/20/22 at 4:40pm. e. Based on record review there was no order available for review for sodium chloride 1 gram tablets in Resident #2's record. Review of Resident #2's July 2022 printed medication administration record (MAR) revealed: -There was an entry for sodium chloride 1 gram take one tablet daily, scheduled for 8:00am. -There was documentation sodium chloride 1 gram was administered from 07/01/22 to 07/31/22 at 8:00am. -There were no exception notes written on the MAR for folic acid. Review of Resident #2's August 2022 printed MAR revealed: -There was an entry for sodium chloride 1 gram take one tablet daily, scheduled for 8:00am.	C 330	Cont on C 330 FL-2 update on 10/21/22.	

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 _____	09/20/2022

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 330	Continued From page 26 -There was documentation sodium chloride 1 gram was administered from 08/01/22 to 08/31/22 at 8:00am. -There were no exception notes written on the MAR for folic acid. Review of Resident #2's printed MAR for 09/01/22-09/20/22 revealed: -There was an entry for sodium chloride 1 gram take one tablet daily, scheduled for 8:00am. -There was documentation sodium chloride 1 gram was administered from 09/01/22 to 09/20/22 at 8:00am. -There were no exception notes written on the MAR for folic acid. Observation of Resident #2's medications on hand on 09/20/22 at 12:59pm revealed there was no sodium chloride 1 gram available to administer to Resident #2. Review of Resident #2's pharmacy dispense records on hand revealed there was no record of sodium chloride 1 gram dispensed for Resident #2. Interview with Resident #2 on 09/20/22 at 3:40pm revealed he did not recall his physician ordering sodium chloride for him. Interview with the Supervisor of Charge (SIC) on 09/20/22 at 3:51pm revealed: -She did not know Resident #2's sodium chloride was not available to administer. -She documented administering Resident #2's sodium chloride in September 2022. Attempted telephone interview with Resident #2's PCP on 09/20/22 at 2:45pm.	C 330	Cont on C 330 FL-2, MAR, and Physician order updated. The administrator will ensure supply and order medications on time before they run out to avoid deficiency from occurring again.	

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 _____	09/20/2022

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 330	Continued From page 27 Attempted telephone interview with Resident #2's pharmacy on 09/20/22 at 3:00pm. Refer to the interview with the Administrator on 09/20/22 at 4:40pm. f. Based on record review there was no order for tamsulosin available for review in Resident #2's record. Review of Resident #2's July 2022 printed medication administration record (MAR) revealed: -There was an entry for tamsulosin 0.4mg take one capsule at bedtime, scheduled for 8:00pm. -There was documentation tamsulosin 0.4mg was administered from 07/01/22 to 07/31/22 at 8:00pm. -There were no exception notes written on the MAR for tamsulosin. Review of Resident #2's August 2022 printed MAR revealed: -There was an entry for tamsulosin 0.4mg take one capsule at bedtime, scheduled for 8:00pm. -There was documentation tamsulosin 0.4mg was administered from 08/01/22 to 08/31/22 at 8:00pm. -There were no exception notes written on the MAR for tamsulosin. Review of Resident #2's printed MAR for 09/01/22-09/20/22 revealed: -There was an entry for tamsulosin 0.4mg take one capsule at bedtime, scheduled for 8:00pm. -Tamsulosin 0.4mg was documented as administered from 09/01/22 to 09/20/22 at 8:00pm. -There were no exception notes written on the MAR for tamsulosin.	C 330	Cont on C 330 FL-2 updated. The administrator will continue to monitor FL-2, MAR and Physician order to ensure deficiency does not occur again.	

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 _____	09/20/2022

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 330	Continued From page 28 Observation of Resident #2's medications on hand on 09/20/22 at 12:59pm revealed there was no tamsulosin available to administer to Resident #2. Review of Resident #2's pharmacy dispense record on hand revealed there was no record of tamsulosin dispensed for Resident #2. Interview with the Supervisor of Charge (SIC) on 09/20/22 at 3:51pm revealed: -She did not know Resident #2's tamsulosin was not available to administer. -She documented administering Resident #2's tamsulosin in September 2022. Interview with the Administrator on 09/20/22 at 4:40pm revealed he did not know there was no tamsulosin available to administer to Resident #2. Attempted telephone interview with Resident #2's PCP on 09/20/22 at 2:45pm. Attempted telephone interview with Resident #2's pharmacy on 09/20/22 at 3:00pm. Refer to the interview with the Administrator on 09/20/22 at 4:40pm. _____ Interview with the Administrator on 09/20/22 at 4:40pm revealed he was responsible for ensuring medications were administered as ordered by the PCP.	C 330	Continued on C 330 FL-2 updated on 10/21/22. The administrator will monitor the SIC to ensure that deficiency does not occur again.	
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration	C 342	Reference to C 342 10A NCAC 13G 1004(j) Medication Administration Resident #2, new FL-2 obtained. MAR obtained to match his FI-2.	

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 _____	09/20/2022

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 342	Continued From page 29 record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of medication administration records for 1 of 3 sampled residents (#2), including a medication used for certain mental health/mood conditions. The findings are: Review of Resident #2's current FL-2 dated 11/19/21 revealed: -Diagnoses included affective psychosis, paranoid schizophrenia, hypertension, obesity, depression, hypothyroidism, alcohol use disorder, and hyperlipidemia. -There was a medication order for risperidone 3mg one tablet in the morning and in the evening.	C 342	With ref to C 342 MAR has been updated to capture all the necessary tools: resident's name, date of birth etc. Current FL-2 updated 10/21/22 the administrator will continue to monitor MAR to ensure proper documentation. The administrator will monitor MAR for proper documentation.	

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 _____	09/20/2022

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 342	Continued From page 30 Review of Resident #2's July 2022, August 2022, and September 2022 printed medication administration records (MAR) revealed: -There was an entry for risperidone 2 mg daily, scheduled for 8:00am. -Risperidone 2mg was documented as administered from 07/01/22 to 09/20/22 at 8:00am. -There was another entry for risperidone 2mg take one and one-half tablet (3mg) at bedtime, scheduled for 8:00pm. -Risperidone 3mg was documented as administered from 07/01/22 to 09/19/22 at 8:00pm. Observation of Resident #2's medications on hand on 09/20/21 at 12:41pm revealed: -There were two bottles of risperidone 3mg tablets available for administration. -One bottle of risperidone tablets was dispensed on 07/25/22. -The second bottle of risperidone tablets was dispensed on 09/13/22. -Both bottles had 180 tablets of risperidone dispensed. Interview with the medication aide (MA) on 09/20/22 at 3:51pm revealed: -She used the bottle of 3mg risperidone tablets to administer to Resident #2. -She had not realized that the dosage for the morning dose did not match the dose she administered. -She did not correct the dosage indicated on Resident #2's MARs because she did not know it was incorrect. Interview with the Administrator on 09/20/22 at 4:45pm revealed: -The pharmacy provided MARs for the facility.	C 342	Continued on C 342 FL-2 reviewed and updated on 10/21/22. The Administrator will continue to monitor to ensure that deficiency does not occur again.	

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 _____	09/20/2022

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 342	Continued From page 31 -He received the next month's MARs and placed them in the MAR book. -He reviewed the new MARs by comparing them to the previous months MARs. -He did not know why Resident #2's risperidone morning dose was inaccurate on the MAR. -Resident #2 used a different pharmacy versus the other 4 residents. -He did not know staff were documenting administration of 2mg of risperidone to Resident #2 on his MARs. -He was responsible for ensuring residents' MARs were accurate. Attempted telephone interview with Resident #2's pharmacy on 09/20/22 at 3:00pm.	C 342		
C 415	10A NCAC 13G .1201 (a) Resident Records 10A NCAC 13G .1201 Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Facility Services and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21);	C 415	With reference to C 415 10A NCAC 13G.1201 (a) Resident Records (1) FL-2 or MAR forms and patient transfer form or hospital discharge summary when applicable; (2) Resident Register; (3) Receipt; (A) Contract; (B) house rules; (C) Declaration of Residents' Rights	

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 _____	09/20/2022

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 415	Continued From page 32 (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain resident records in an orderly manner at the facility for 3 of 3 (#1, #2, and #3) sampled residents. The findings are: 1. Based on record review, the following documents were not readily available for Resident #1: current care plan or statement of assessed need signed by the physician; orders or written treatments or procedures from a physician or other licensed health professional and their implementation; and contacts with the resident's physician, physician services or other licensed	C 415	Continued on C 413 all care plans has been updated and licensed health care professional support has been updated. Care plan completed on 10/21/22. The Administrator will continue to monitor periodically to ensure deficiency does not occur again. Care plan signed by Resident Physician on 10/21/22. The Administrator will monitor all the time to ensure to ensure deficiency does not occur again.	

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 _____	09/20/2022

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 415	Continued From page 33 health professional. Refer to interview with a medication aide (MA) on 09/20/22 at 3:57pm. Refer to the interview with the Administrator on 09/20/22 at 4:38pm. 2. Based on record review, the following documents were not readily available for Resident #2: a current care plan or statement of assessed need signed by the physician (care plan was dated 07/22/21/not signed by Resident #2's physician); a completed Resident Register was not readily available for Resident #2. (Pages 1 and 2 were minimally completed; all other pages were blank); and orders or written treatments or procedures from a physician other licensed health professional and their implementation; and contacts with the resident's physician, physician services or other licensed health professional. Refer to interview with a medication aide (MA) on 09/20/22 at 3:57pm. Refer to the interview with the Administrator on 09/20/22 at 4:38pm. 3. Based on record review, the following documents were not readily available for Resident #3: current care plan or statement of assessed need signed by the physician (care plan was dated 04/15/21); orders or written treatments or procedures from a physician or other licensed health professional and their implementation. Refer to interview with a medication aide (MA) on 09/20/22 at 3:57pm. Refer to the interview with the Administrator on	C 415	The administrator will ensure that C 415 care plan and licensed healthcare professional updated in accordance to C 415 10A NCAC 13G .1201. Updated on 10/21/22.	

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 _____	09/20/2022

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 415	Continued From page 34 09/20/22 at 4:38pm. _____ Interview with a MA on 09/20/22 at 3:57pm revealed: -She began working at the facility on 09/04/22. -When residents went to physician appointments and returned with paperwork, she placed the paperwork in the resident's record. -She noticed that not all residents returned from appointments with paperwork. Interview with the Administrator on 09/20/22 at 4:38pm revealed: -He was responsible for auditing the records, but he had not completed a recent audit. -He took residents to appointments and obtained signed documents from the physician's office. -He had requested medication orders for residents to be faxed to the facility from the pharmacy. -He had not received the medication orders for residents at that time and was waiting for faxes from the pharmacy. -He was responsible for ensuring all the required documents were available for review and in residents' records.	C 415	Continued from 415. The administrator will continue to monitor when resident returns form. appointment. All new orders will be documented for proper resident care.	
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	C 612	With reference to C 612 10A NCAC 13G .1701 INFECTION PREVENTION CONTROL PROGRAM the Administrator has redirected every one in the facility to put on mask to ensure the policy according to CDC.	

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 _____	09/20/2022

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 612	Continued From page 35 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 to 5 residents during the global coronavirus (COVID-19) pandemic as related to the use of facemasks by staff. The findings are: Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic updated 02/02/22 revealed: -Source control measures were to be implemented for HCP. -Source control referred to the use of well-fitting facemasks to cover a person's mouth and nose to prevent the spread of respiratory secretions when the person was breathing, talking,	C 612	Guidance or directive specific to communicable disease will be implemented by the facility. Reference to C 612 COVID-19 vaccine has been completed by staff and residents. As of date 11/07/22. The Administrator will ensure that all staff and resident continue to put face mask. Visitors are required to put face mask.	

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 _____	09/20/2022

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 612	Continued From page 36 sneezing, or coughing. -Fully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. Review of the NC DHHS COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 02/10/22 revealed: -Cloth masks were not considered personal protective equipment (PPE) and should not be worn by staff. -Visitors should wear face coverings or face masks when around other residents or healthcare personnel. -DHHS continued to recommend facilities, residents, families and visitors adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure. -Visitors who were unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. Observation of the facility's front door on 09/20/22 at 8:06am revealed there was no signage providing guidance concerning face masks. Observation of the Administrator upon entrance into the facility on 09/20/22 at 9:40am revealed: -He came from the foyer and hallway without a face mask and entered the common area for residents. -There were two residents sitting in the living room. Interview with the Administrator on 09/20/22 at 4:46pm revealed he did not know the CDC guidelines related to long term care and staff at the facility did not wear a face mask at all times in the facility.	C 612	Cont. on C 612 the administrator will monitor and ensure that staff and visitors wear face masks hence DHHS continue to recommend facilities to adhere to the core principles of COVID-19 Infection prevention.	

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 _____	09/20/2022

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 612	Continued From page 37 Observation of a medication aide (MA) on 09/20/22 at 8:35am revealed she met visitor in the foyer without a face mask and there were no residents present. Observation of the MA on 09/20/22 at 11:00am revealed she was cleaning and mopping resident areas with her face mask pulled down below her nose and chin. Interview with the MA on 09/20/22 at 9:43am revealed: -She knew she was supposed to wear a face mask in the facility. -She had worked as a MA at various facilities. -She wore a face mask when she was near residents or in resident areas of the facility. Observation of the Administrator on 09/20/22 at 2:45pm revealed he exited the front entrance of the facility without a face mask with a resident. Interview with the Administrator on 09/20/22 at 4:40pm revealed: -He thought the CDC guidelines were that staff should wear face masks while in the facility. -He took her face mask off throughout the day because she felt like she could not breath. -When there were visitors in the facility or when they were out of the facility with the residents, all staff were expected to wear the surgical mask and to ensure their nose and mouth were covered.	C 612	All staff must put where a surgical face mask and to ensure that nose and mouth are covered. The Administrator will monitor to ensure that deficiency does not occur again.	