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
	HAL063022	A. BUILDING: _____ B. WING _____	R 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX HOLLOW SENIOR LIVING COMMUNITY	190 FOX HOLLOW PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Moore County Department of Social Services conducted an annual and follow-up survey on 12/11/23 through 12/12/23.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) as evidenced by 6 of 11 fixtures with water temperatures ranging from 117 to 123.1 degrees F. The findings are: Observations of the water temperatures on the second floor assisted living (AL) hall on 12/11/23 from 9:18am to 9:50am revealed: -The water temperature in the bathroom sink in room 236 was 118.2 degrees F. -The water temperature in the bathroom sink in room 233 was 119.3 degrees F. Second observation of the water temperatures on the second floor AL hall on 12/11/23 from 3:58pm to 4:08pm revealed:	D 113	**10 NCAC 13F .0311 (d) Other Requirements** The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soil utility room. The Rule was not met in 6 of the 11 fixtures with water temperature ranging from 117-123.1 degrees F. Plan of Correction: The community will designate a team member to take water temperatures at least five times a week in selected apartments and common areas. The community will address the temperatures if they are not within the range of 100-116 degrees F by adjusting the water temperatures and or contacting a vendor to address additional issues as needed. Completion Date: January 25, 2024	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Machelle Nydia Brooks | TITLE: Executive Director | (X6) DATE: 1-30-2024

RECEIVED AND ACKNOWLEDGED ON 01/31/24 BY NURSE CONSULTANT Tina B Nielsen

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D 113	Continued From page 1 -The water temperature in the bathroom sink in room 236 was 123.1 degrees F. -The water temperature in the bathroom sink in room 233 was 115.2 degrees F. Interview with a resident on the second floor AL hall on 12/11/23 at 4:05pm revealed: -He had not noticed the water in his room being too hot. -He could turn on the cold faucet if he thought the water felt too hot. Interview with the Maintenance Director on 12/11/23 at 4:08pm revealed: -He adjusted the water heater this morning, 12/11/23. -He checked the water temperatures weekly and recorded them on a log. -He would contact a plumber to come to the facility and determine why the water temperature continued to be over 116 degrees F. -He would place signs in room 236 room to caution the resident about the hot water temperature. Third observation of room 236 on 12/12/23 from 8:40am to 8:46am revealed: -The Maintenance Director and a plumber were checking the water temperature in the resident's room. -The water temperature in the bathroom sink in room 236 was 113.2 degrees F. Review of the facility's water temperature logs from September 2023-December 2023 revealed: -The Maintenance Director recorded temperatures from various resident rooms throughout the facility each week. -Water temperature readings for September 2023 ranged from 105-116 degrees F.	D 113		

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D 287	Continued From page 3 (b) Food Preparation and Service in Adult Care Homes: (2) Hot foods shall be served hot and cold foods shall be served cold as set forth in Rule 15A NCAC 18A .1620(a) for facilities with a licensed capacity of 7 to 12 residents and as set forth in Rule 15A NCAC 18A .1323 Food Protection in Activity Kitchens, Rehabilitation Kitchens, and Nourishment Stations for facilities with a licensed capacity of 13 or more residents, which are hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure hot foods were maintained hot (135 degrees Fahrenheit (°F) or higher) until the Special Care Unit (SCU) residents were ready to eat their meals. The findings are: Observation of the breakfast meal service on 12/12/23 at 7:20am revealed: -There was a portable warmer that was plugged in and set at a temperature of 170 degrees. - On top of the warmer were serving dishes that contained scrambled eggs, link sausage, grits, blueberry muffin, or blueberry bread. -The PCAs and MA were serving the residents plates from the serving dishes and then taking the plates to the residents who were seated at the dining room tables. Observation of the lunch meal service on 12/12/23 at 11:29am revealed: -There was a portable warmer that was plugged	D 287		

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D 113	Continued From page 2 -Water temperature readings for October 2023 ranged from 102-116 degrees F. -Water temperature readings for November 2023 ranged from 109-115 degrees F. -Water temperature readings for December 2023 ranged from 109-116 degrees F. Second interview with the Maintenance Director on 12/12/23 at 3:40pm revealed: -The plumber was at the facility this morning and recommended installing another mixing valve for the water heater to help maintain the proper water temperature. -The mixing valve had been ordered. -If he had any water temperature readings over 116 degrees F, he would adjust the water heater to bring the temperature to 116 degrees F or less. Interview with the Administrator at on 12/12/23 at 3:55pm revealed: -The water temperature in resident rooms should not exceed 116 degrees F. -It was the responsibility of the Maintenance Director to check the water temperatures every week. -If any readings were more than 116 degrees F, then the Maintenance Director should adjust the water heater and recheck water temperatures the same day. -If the water temperatures remained higher than 116 degrees F, the Maintenance Director should report the temperatures to her, and she would contact an outside vendor for water repairs and adjustments when needed.	D 113		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service	D 287		

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D 287	Continued From page 4 in and set at a temperature of 170 degrees. - On top of the warmer were serving dishes that contained stuffed portobella mushrooms, Cuban sandwiches, steamed broccoli, and roasted potato wedges. -The SCU resident received a choice of stuffed portobella mushrooms or a Cuban sandwich which were served from the serving dishes on top of the warmer. -The PCAs and the SCUC were serving the residents plates from the serving dishes and then taking the plates to the residents who were seated at the dining room tables. Observation of the lunch meal service on 12/12/23 at 12:00pm revealed: -The melted cheese on the Cuban sandwich was no longer soft in appearanceafter being out of the warmer. -There was minimal warmth noted on the top of the warmer where the serving plates were located. -A female resident arrived to the dining room for lunch. -Her food was plated and served from the serving plates that remained on top of the warmer. -The surveyor requested 3 potato wedges from the PCA. -The PCA removed the 3 potato wedges from the bottom of the remaining potato wedges and plated them on a dessert plate for the surveyor. -The internal temperature of the largest potato wedge was 124.6°F. -The SCUC was made aware of the temperature of the potato wedge. -She instructed the PCAs to return the serving plates to inside the warmer. Interview with the facility's the Food and Beverage Director on 12/12/23 at 1:55pm	D 287	**10 A NCAC 13 F .0904(b) (2) Nutrition and Food Service** This Rule was not met because the community failed to ensure hot foods were maintained hot (135 degrees F or higher) in the Special Care Unit. Plan of Correction: Education provided to the team to ensure they understood that food has to be kept in the warmer until served and once the food is served, it must be returned to the warmer to maintain the hot temperature. Completion Date: December 13, 2023.	

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D 287	Continued From page 5 revealed: -He was not aware that the food sat out of the warmer from 11:30am to 12:00pm. -Food was transported to the SCU in a warmer by dietary staff. -The food should have been put back in the warmer after serving the residents. -The food should have been served at a temperature of 135°F or above. Interview with the Special Care Unit Coordinator (SCUC) on 12/12/23 at 2:15pm revealed: -She was not aware that the food sat out of the warmer from 11:30am to 12:00pm. -The food was transported to the SCU from the main kitchen in a warmer. -The warmer was plugged in and set at a temperature of 170°F. -The food was supposed to be put back in the warmer after serving. -It was her responsibility to follow up and make sure the food was put back in the warmer. Interview with the Administrator on 12/12/23 at 3:40pm revealed: -She was not aware the food in the SCU sat out of the warmer from 11:30am to 12:00pm. -The food was not supposed to be taken out of the warmer until ready to serve. -The remaining food should have been placed back in the warmer until all residents had been served. -In the SCU, the personal care aides (PCAs) and medication aides(MAs) were responsible for serving the food to the residents. -The SCUC was on the SCU for meals and was responsible for following up behind the PCAs and MAs to make sure the food was put back in the warmer.	D 287		

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D 299	Continued From page 6	D 299		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 8 ounces of milk/dairy was served three times daily to the 17 residents of the Special Care Unit (SCU). The findings are: Review of the facility's census on 12/11/23 at 9:15am revealed 68 residents resided at the facility with 51 on Assisted Living and 17 in the SCU. Observation of the SCU on 12/11/23 revealed there was not a menu posted for the meals being served on 12/11/23 or 12/12/23. Observation of the refrigerator in SCU dining room/kitchen on 12/11/23 at 11:45am revealed there was a gallon of whole milk in the	D 299	**10 A NCAC 13 F .0904(b) (2) Nutrition and Food Service** This Rule was not met by not serving milk three times a day to the residents in the Special Care Unit. Plan of Correction: Education was provided to the team to ensure they understood that milk had to be served to the resident for all three meals. Milk is to be offered and served to all residents during breakfast, lunch, and dinner a designee will be assigned to ensure that the task is completed. Completion Date: December 13, 2023.	

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D 299	Continued From page 7 refrigerator. Observation of the breakfast meal service on 12/12/23 at 7:20am revealed: -There was no milk or dairy products offered or served to the 17 residents of the SCU. -The SCU residents received eggs, link sausage, grits, blueberry muffin, or blueberry bread orange juice, water, and coffee for those who requested it. -There was a gallon of whole milk in the refrigerator. Observation of the lunch meal service on 12/12/23 at 11:29am revealed: -There was no milk or dairy products offered or served to the 17 residents of the SCU. -The SCU resident received a choice of stuffed portobella mushrooms or a Cuban sandwich, steamed broccoli, and roasted potato wedges, with water and iced tea. Interview with the facility's Food and Beverage Director on 12/12/23 at 1:55pm revealed: -He was not aware that the residents on the SCU were not offered milk at breakfast or lunch. -Milk should have been offered to all residents. -Dietary staff were responsible for offering milk to all residents. -Milk was available in the kitchen for all residents. Interview with the Special Care Unit Coordinator (SCUC) on 12/12/23 at 2:15pm revealed: -Residents were supposed to be offered milk at every meal. -She was aware residents were not offered milk at breakfast and lunch. -The SCU ran out of milk last night and staff did not bring milk from the AL dining room. -It was her responsibility to follow up and make	D 299		

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D 299	Continued From page 8 sure milk was offered to the residents. Interview of the Administrator on 12/12/23 at 3:40pm revealed: -Milk should have been offered to all residents at least 3 times a day. -The Personal Care Assistants (PCA) and Medication Aides (MA) were responsible for offering milk to all residents. -The SCUC was on the floor for meals and was responsible for following up behind the PCAs and MAs to make sure milk was offered to all residents. -If milk was not available on the SCU, the PCAs and MAs were supposed to call the main dining room to request milk.	D 299		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 7 residents (#6) observed during the medication pass including errors with a controlled substance used to treat anxiety and agitation (#6) and 1 of 5 residents reviewed for a second TB skin test order (#1).	D 358	**10 A NCAC 13F. 1004(a) Medication Administration** This Rule was not met based on 1 of 7 residents not receiving a scheduled controlled substance used to treat anxiety and 1 of 5 residents did not have a 2nd step TB Test. Plan of Correction: The team will order medication from the resident's pharmacy and if the medication is not received within at least one day of the order, the team or designee will follow up with the pharmacy to check on the status. The team will also communicate with the physician if the medication is unavailable. The community will designate an individual to do a weekly audit to follow up on identifying any trends or issues. Plan of Correction: The community will audit residents' immunization records for TB Tests and administer tests for those residents who may require a 2nd step TB test. Completion Date: January 31st, 2024.	

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D 358	Continued From page 9 The findings are: 1. Review of Resident #6's current FL-2 dated 05/09/23 revealed diagnoses included unspecified dementia and anxiety disorder. Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 10/11/21. Observation of the medication pass on 12/12/23 at 8:57am revealed: -Resident #6 received Lexapro 20mg one tablet and Tylenol 500mg 2 tablets. -There was no observation of Xanax 0.5mg being administered to Resident #6 during the medication pass on 12/12/23. Review of Resident #6's December 2023 medication administration record (MAR) revealed: -There was a computer-generated entry for Escitalopram (Lexapro) 20mg 1 tablet by mouth every day. -There was a computer-generated entry for Acetaminophen 500mg (Tylenol) 2 tablets by mouth three times a day as scheduled. -There was a handwritten entry for Xanax (alprazolam) 0.5mg take 1 tablet by mouth twice daily as needed for agitation that had been crossed out without any date or initials. -There was a typed entry for (alprazolam) Xanax 0.5mg take 1 tablet by mouth twice daily for anxiety to be administered at 8:00am and 4:00pm -The 8:00am dose on 12/12/23 was documented as not being given with the reason of being on order. A telephone interview with a pharmacist with the facility's contracted pharmacy on 12/12/23 at	D 358		

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D 358	Continued From page 10 10:52am revealed: - A 30-day supply of Xanax 0.5mg was last filled on 11/10/23 for Resident #6. -The pharmacy had received a faxed order from Resident #6's mental health provider on 11/28/23 to change the Xanax 0.5mg to scheduled once a day at 4:00pm and for it to be given as needed twice a day. -This order had not been filled since the provider's office had not sent a hard copy of the prescription which was required since Xanax was a controlled substance. Observation of Resident #6 on 12/12/23 at 12:00pm revealed: -She had walked down to the SCU dining with her rollator. -She was seated at the dining table and served her lunch. -She was visibly upset and crying. -The personal care aides (PCAs) and Special Care Unit Coordinator (SCUC) talked with her and tried to console her without success. -She said she did not want to eat. -The staff assisted her out of the dining room back to her room. Based on observations and record reviews, Resident #6 was not interviewable. Interview with the Medication Aide (MA) on 12/12/23 at 2:15pm revealed: -She was unsure why Resident #6's Xanax was not available for administration. -She administered the Xanax to the resident on 12/11/23. -She did not know why there was a delay in getting it from the pharmacy for the resident. -The MAs were responsible for removing the red tab stickers from the medication cards and faxing	D 358		

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D 358	Continued From page 11 them to the pharmacy when there was 7-10 days of the medication remaining. Interview with the Administrator on 12/12/23 at 3:30pm revealed: -She was not aware that Resident #6 was not administered her Xanax as ordered on 12/12/23. -She expected that the MAs reordered medications when there were 7-10 days remaining. -The SCUC was responsible for checking behind the MAs on the SCU to ensure that medications were available for administration. Telephone interview with Resident #6's PCP on 12/12/23 at 11:12am was unsuccessful. Review of the physician orders provided by the Administrator on 12/12/23 at 4:00pm revealed: -The physician orders were dated 11/28/23 and electronically signed by the PCP on 12/12/23. -There was an order for the Xanax 0.5mg to be changed to be given as scheduled once a day at 4:00pm and for it to be given as needed twice a day. A second interview with the Administrator on 12/12/23 at 4:00pm revealed: -She had contacted the PCP regarding the Xanax order to see if the hard copy had been sent by the PCP to the pharmacy. -She had been sent the PO's electronically signed on 12/12/23 for the date of service on 11/28/23 that included the order for the Xanax 0.5mg but the hard copy had not been sent prior to that day (12/12/23). 2. Review of Resident #1's FL-2 dated 12/23/22 revealed: -Diagnoses included type 2 Diabetes Mellitus,	D 358		

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D 406	Continued From page 13 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that action was taken in response to a quarterly medication review recommendation for 1 of 5 sampled residents (#2) related to a medication used to treat arthritis. The findings are: Review of Resident #2's FL2 dated 03/21/23 revealed no list of current diagnoses. Review of Resident #2's primary care provider's (PCP) initial visit note dated 04/07/23 revealed Resident #2's past medical history included diagnoses of osteoarthritis, gastroesophageal reflux disease (GERD), dementia, anemia, and hypertension. Review of Resident #2's Resident Record revealed an order dated 07/28/23 for Mobic 7.5 mg twice daily (Mobic is a medication used to treat arthritis). Review of Resident #2's pharmacy consultation report dated 10/30/23 revealed: -The pharmacist recommended that Mobic was to be taken with food/meals and to follow proper administration guidelines. -The report was signed by the Director of Resident Care (DRC) and dated 12/11/23. Review of Resident #2's October 2023 medication administration record (MAR) revealed: -An entry for Mobic 7.5mg one tablet by mouth twice daily scheduled for 8:00am and 8:00pm. -Mobic was documented as administered on 10/01/23 to 10/31/23 at 8:00am and 8:00pm.	D 406	**10 NCAC 13F .1009(b) Pharmaceutical Care** This Rule is not met because the community did not follow up with the quarterly pharmacy recommendations timely. Plan of Correction: The community will ensure that once the quarterly pharmacy review is completed by the pharmacy within one week the team will send the recommendations to the primary care physician and if no response within one week, a designee will follow up with the provider. Completion Date: January 31st, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063022	A. BUILDING: _____ B. WING _____	R 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 12 degenerative disc disease, osteoporosis, hypertension, chronic kidney disease stage 3, and cirrhosis. -There was an order "may administer 2nd step TB test". Review of Resident #1's FL-2 dated 08/08/22 revealed: -Diagnoses included type 2 Diabetes Mellitus, degenerative disc disease, osteoporosis, hypertension, chronic kidney disease stage 3, and cirrhosis. -There was an order "may administer 2nd step TB test". Interviews with the Facility Nurse on 12/12/23 at 8:27am and 12:17pm revealed: -She was not aware that there was an order on Resident #1's FL-2 dated August 2022 and December 2022 for Resident #1's step 2 TB test to be administered because she was not employed at this facility when those FL2s were completed. -The first TB test was completed prior to Resident #1 being admitted to the facility on 08/08/22. -The second step TB test was not administered until 12/12/23.	D 358		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary.	D 406		

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D 406	Continued From page 14 Review of Resident #2's November 2023 MAR revealed: -An entry for Mobic 7.5mg one tablet by mouth twice daily scheduled for 8:00am and 8:00pm. -Mobic was documented as administered on 11/01/23 to 11/30/23 at 8:00am and 8:00pm. Review of Resident #2's December 2023 MAR revealed: -An entry for Mobic 7.5mg one tablet by mouth twice daily scheduled for 8:00am and 8:00pm. -Mobic was documented as administered on 12/01/23 to 12/10/23 at 8:00am and 8:00pm. Review of Resident #2's physician order sheet dated 12/11/23 revealed documentation of a verbal order to change the current Mobic order time from 8:00am and 8:00pm to 8:00am and 5:00pm with food/meals. Interview with Resident #2 on 12/12/23 at 9:20am revealed she had a history of acid reflux and sometimes experienced episodes of diarrhea but had no complaints of stomach pain. Interview with a pharmacist at the facility's contracted pharmacy on 12/12/23 at 10:54am revealed: -Mobic was a nonsteroidal anti-inflammatory drug (NSAID) that could cause gastrointestinal side effects. -Taking Mobic with food could help decrease the risk of stomach irritation. -The long-term use of Mobic being taken without food could increase the risk of stomach ulcers. Interview with the DRC on 12/12/23 at 11:12am revealed: -The facility's contracted pharmacist emailed the quarterly medication review and	D 406		

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D 406	Continued From page 15 recommendations to her and the Administrator within 24 hours of completing them. -It was her responsibility to send the recommendations to the resident's PCPs. -The recommendations were faxed to the residents' PCPs or placed in a folder for the PCP that came to the facility. -She did not have an explanation as to why the recommendation dated for 10/30/23 was not addressed until 12/11/23. Interview with the Administrator on 12/12/23 at 11:20am revealed: -The facility's contracted pharmacist sent an email containing the quarterly medication review and recommendations to her and the DRC after the medication review was completed. -It was the responsibility of the DRC to print the pharmacist's recommendations and send them to the residents' PCPs. -The PCP that came to the facility each week had a folder to review items that needed to be signed and pharmacy recommendations for that PCP were placed in the folder. -The recommendations should have been sent out or given to the PCPs within the week they were received. -She was unsure if Resident #2's PCP had seen the recommendation to change the administration times for Resident #2's Mobic. Interview with Resident #2's PCP on 12/12/23 at 3:10pm revealed: -The facility had a folder for her to review information when she came to the facility to see residents. -The facility usually placed pharmacy recommendations in the folder for her review. -She had not seen the recommendation dated 10/30/23 regarding the administration time	D 406		

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D 406	Continued From page 16 change on Resident #2's Mobic. -She gave a telephone order to the facility's DRC on 12/11/23 to change Resident #2's Mobic to be given twice daily with meals.	D 406		