

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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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 survey and a follow-up survey on 01/17/24 to 01/18/24.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any	C 007		

RECEIVED

FEB 14 2024

ADULT CARE LICENSURE SECTION
RALEIGH

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Maurice Achu

TITLE

Administrator

(X6) DATE

2/13/24

STATE FORM

6599

1XJP11

If continuation sheet 1 of 91

Reviewed and acknowledged on 02/27/24.

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C 007	Continued From page 1 possible changes that may be required to the building. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that the resident's evacuation capabilities were different from the evacuation capabilities listed on the facility's license for 1 of 4 sampled residents (#3,) who did not exit the facility during a fire drill. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents. Observation of the facility on 01/17/24 at 8:30am revealed: -Four residents resided in the facility. -One resident was seated on the sofa in the television room. -Two residents were in their bedrooms -A fourth resident was slumped over in a wheelchair in the television room. Observation of Resident #3 on 01/17/24 at various times between 1:27pm and 4:13pm revealed: -The resident was seated in a wheelchair with his chin touching his chest. -At 1:27pm, he attempted to propel his wheelchair by placing his hands on the wheels and pushing them forward but was only able to pivot the	C 007	All residents shall be assessed to ensure they have the capabilities to be able to move with little assistance in case of any emergency including a fire. This shall be done by the SIC and/or administrator. If a resident is deemed not to have the capabilities to be able move with little assistance, the Administrator shall find suitable living situation for safety.	2/8/24

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C 007	Continued From page 2 wheelchair in a quarter turn. -At 1:39pm, he attempted to propel his wheelchair again by placing his hands on the spokes of the wheels but was only able to pivot his wheelchair another quarter turn. -At 4:08pm, the Supervisor-in-Charge (SIC) pushed the resident in his wheelchair into the television room; the SIC left the room and did not turn the resident so he was completely in the room or facing the television. -The resident placed his hands on the wheels of his wheelchair and attempted to propel the chair forward; his chin was touching his chest and he moaned and grunted as he tried to move forward into the room. -At 4:09pm, the resident was still attempting to propel his wheelchair forward. -At 4:10pm, the resident had propelled his wheelchair forward approximately three feet; his back was still to the television. -The resident continued to attempt to move the wheels on his wheelchair with his hands. -At 4:13pm, the resident had turned his wheelchair 180 degrees by pivoting a quarter turn at a time. Review of the facility's fire rehearsal schedule revealed: -On 01/01/23 at 6:30 (am/pm were not indicated), all residents were directed to the front of the building for safety; the evacuation time was two minutes. -On second shift on 01/01/23 there was documentation the same procedure was taken to ensure patient safety; the evacuation time was one and a half minutes and all residents were moved to the back of the building "since the fire was coming from the front". -On 06/01/23 at 4:00am all residents were asked to move to the front of the building for safety by	C 007		

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C 007	Continued From page 3 the Administrator and the staff; the evacuation time was one and a half minutes. -On second shift on 06/01/23, no time was documented, all residents were ordered to the front of the building for safety; the evacuation time was one minute and 45 seconds. Interviews with Resident #3 on 01/17/24 at 11:05am and 4:28pm revealed: -Some days were better than others and he could walk on his own. -During the last fire rehearsal, he could not walk out on his own and the Administrator pushed him outside. -The last fire drill he had participated in where he walked out was three to six months ago. -He had gotten weaker in the last six months. -He had the wheelchair for about six months. -He did not exit the facility when the fire alarm sounded because he was seated in his wheelchair. -Staff helped him during a fire drill by pushing him out of the facility. -He could propel his own wheelchair during a fire drill, but it would take him "an hour" to exit. -If there was a real fire, he might have to leave his chair. -He could walk out during a fire drill if his legs were not tired; his legs could get very tired and his balance was also bad. -He would try to walk out during a real fire, but he was not sure if he could do it. Interview with the Supervisor-in-Charge (SIC) on 01/17/24 at 12:11pm revealed: -The Administrator conducted the fire drills and he participated. -He did not know what the Division of Health Service Regulation (DSHR) was or if the Administrator had contacted someone with the	C 007			

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C 007	Continued From page 4 Construction Section regarding a resident's evacuation capabilities. -An outside organization had done a fire drill with the Administrator, but he was not sure who the agency was. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful.	C 007		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 4 sampled residents (#3) who did not respond to the fire drill. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of six ambulatory residents.	C 022	Fire drills will be completed monthly at different times of the day by SIC and/or administrator. Documentation shall be kept of each fire drill with detail information of time of day, the time it took all to exit and names of all that was	

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C 022	Continued From page 5 Observations of the facility during the initial tour on 01/17/24 at 8:30am revealed: -Four residents resided in the facility. -There was one staff, a Supervisor-in-Charge (SIC) who resided in the facility. -There was no sprinkler system installed in the facility. -There were two entrances/exits with ramps. -Resident #3 was in a wheelchair; he was slumped forward with his chin resting on his chest. Review of Resident #3's current FL2 dated 10/24/23 revealed: -Diagnoses included hypertension, hyperlipidemia, schizophrenia and hypothyroidism. -He was semi-ambulatory; no assistive device was listed. -There was nothing documented regarding personal care needs. Review of Resident #3's assessment and care plan dated 06/01/23 revealed: -The resident was ambulatory with aide or device; the device was not listed. -The resident had limited range of motion in his upper extremities. -The resident was totally dependent on staff for toileting, transferring, eating, dressing, bathing, and grooming. -There was no documentation for the level of assistance needed for ambulation/locomotion. Observation of a fire drill on 01/17/24 from 4:21pm to 4:25pm revealed: -There were three residents present during the fire drill; one resident was seated outside on the front porch.	C 022	involved. This with continue going forward.	2/7/24

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C 022	Continued From page 6 -One resident was in his room with the door closed and two residents were seated in the television room watching television including Resident #3 who was sitting in his wheelchair. -At 4:21pm, the SIC set off the fire alarm at a control panel; a loud alarm sounded with a flashing light in the hallway and at the entrance to the facility. -At 4:24pm the resident in his room exited the facility and stayed on the porch. -Resident #3 and another resident who were in the television room remained seated and did not exit the facility during the fire drill. -At 4:25pm, the SIC turned off the fire alarm. Observations of Resident #3 on 01/17/24 at various times between 8:30am to 4:40pm revealed: -At 8:30am, Resident #3 was sitting in a wheelchair in the television room. -At 9:49am, the SIC pushed Resident #3 into the television room. -At 11:49am, the SIC pushed Resident #3 in his wheelchair from the television room to his place at the dining room table for lunch. -After lunch the SIC pushed Resident #3 in his wheelchair into the television room. -At 12:09pm, the SIC propelled Resident #3 into the bathroom from the television room. -At 1:27pm, Resident #3 attempted to move his wheelchair by using his hands on the wheels but was unable to move forward. -At 1:39pm, he attempted to propel his wheelchair again by placing his hands on the spokes of the wheels but was only able to pivot his wheelchair another quarter turn. -The resident placed his hands on the wheels of his wheelchair and attempted to propel the chair forward; his chin was touching his chest and he moaned and grunted as he tried to move forward	C 022		

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C 022	Continued From page 7 into the room. -At 4:09pm, the resident was still attempting to propel his wheelchair forward. -At 4:10pm, the resident had propelled his wheelchair forward approximately three feet; his back was still to the television. -The resident continued to attempt to move the wheels on his wheelchair with his hands. -At 4:13pm, the resident had turned his wheelchair 180 degrees by pivoting a quarter turn at a time. -At 3:12pm, another resident pushed Resident #3 in his wheelchair to the bathroom. -At 4:08pm, the SIC pulled Resident #3 backwards in his wheelchair from the bathroom to the television room; Resident #3 attempted to move his wheelchair by using his hands on the spokes of the wheels but did not move forward or backwards. -At 4:40pm, the SIC pushed Resident #3 to the dining room table. Observation of Resident #3 on 01/18/24 at various times between 8:33am to 4:10pm revealed: -At 8:33am, Resident #3 was seated in his wheelchair in the television room. -At 12:10pm, the SIC pushed Resident #3 in his wheelchair to the dining room table and positioned the wheelchair for lunch. -At 1:35pm, Resident #3 requested the SIC push him in his wheelchair to the bathroom. -At 1:45pm, Resident #3 called for the SIC to assist him in the bathroom; the SIC pushed him in his wheelchair from the bathroom back to the television room. -At 3:23pm, Resident #3 requested for the SIC to push him in his wheelchair to the bathroom. -At 4:10pm, Resident #3 called for the SIC from the bathroom; the SIC assisted Resident #3 up	C 022			

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C 022	Continued From page 8 from the commode and pulled his pants up for him; Resident #3 lowered himself into his wheelchair and the SIC pushed him in his wheelchair from the bathroom to the television room. Observation of a fire drill on 01/18/24 from 4:02pm to 4:07pm revealed: -There were four residents in the facility during the fire drill. -Two residents were in their rooms with the doors closed, one was in the television room on the sofa, and Resident #3 was in the bathroom. -At 4:02pm, one resident in his room and the resident from the television room exited the facility. -At 4:04pm, the third resident exited from his room. -At 4:07pm, the SIC turned off the fire alarm. -Resident #3 did not exit the bathroom. Interviews with a resident on 01/17/24 at 11:05am and 12:36pm revealed: -The Administrator brought the wheelchair to Resident #3 about six months ago. -They had a fire drill about five months ago; he thought the fire department was at the facility at the last fire drill. -The Administrator pulled the alarm and then said "fire" and told the residents to go outside. -The residents met on the front porch. -The Administrator or the SIC pushed Resident #3 in his wheelchair outside to the porch because it was faster. -He pushed Resident #3 in his wheelchair around the facility sometimes because he needed help when the SIC was not around. -Resident #3 could not always push his own wheelchair and would ask whoever was around to help him.	C 022			

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C 022	Continued From page 9 -Sometimes Resident #3 would walk to the bathroom and then he would have to bring the wheelchair to Resident #3 because he could not walk back. Third interview with the resident on 01/17/24 at 4:25pm revealed: -He did not exit the facility when he heard the fire alarms because he thought the SIC was only testing the alarm. -The SIC did not announce there was going to be a fire drill and did not tell him to get out during the drill, so he did not leave. -The Administrator was not there, and the Administrator told him to leave when there was a fire drill. Interview with a second resident on 01/17/24 at 1:07pm revealed: -Resident #3 got weaker and weaker and could not use a walker anymore. -Resident #3 started to use the wheelchair about six months ago because he could not walk anymore. -The last fire drill was about 10 months ago. -He thought the fire alarm company was at the facility with the Administrator and they turned on the alarm. -The only time they had fire drills was when the fire alarm company came to the facility; they did not do routine fire drills. -Sometimes the Administrator would give a verbal notice before they turned on the alarm. -The Administrator would make sure the residents got outside during the fire drills. -The Administrator would say "fire drill" or "we got to go outside". -Since Resident #3 had been using a wheelchair the SIC or the Administrator pushed him outside. -Resident #3 could use the wheelchair on his own	C 022		

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C 022	Continued From page 10 but would ask for help. Interview with Resident #3 on 01/17/24 at 11:05am revealed: -He could walk to the bathroom from the television room on his own on a good day. -Some days were better than others and he could walk on his own. -During the last fire rehearsal, he could not walk out on his own and the Administrator pushed him outside. -The last fire drill he had participated in where he walked out was three to six months ago. -He had gotten weaker in the last six months. -He had fallen before he got the wheelchair, but he had not fallen since. -He had the wheelchair for about six months. -The Administrator gave him the wheelchair. Second interview with Resident #3 on 01/17/24 at 4:28pm revealed: -He did what everyone else did during a fire drill; no one left this time. -There had not been a fire drill without the staff announcing one. -He did not exit the facility when the fire alarm sounded because he was seated in his wheelchair. -Staff helped him during a fire drill by pushing him out of the facility. -He could propel his own wheelchair during a fire drill, but it would take him "an hour" to exit. -If there was a real fire, he might have to leave his chair. -He could walk out during a fire drill if his legs were not tired; his legs could get very tired and his balance was also bad. -He would try to walk out during a real fire, but he was not sure if he could do it.	C 022		

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C 022	Continued From page 11 Interviews with the SIC on 01/17/24 at 9:49 AM and 12:14pm revealed: -Resident #3 used a wheelchair to ambulate but could walk on his own. -Resident #3 used the wheelchair when he was weak and could not get up on his own. -Resident #3 could get out of the bed on his own and did not require any assistance. -During a fire drill he would make sure Resident #3 was taken out first because he was in a wheelchair and he could not move. -The other residents in the facility would not help Resident #3 during a fire drill. -Resident #3 could move the wheelchair with his hands but he was slow. -Resident #3 could not always move his wheelchair by himself. Third interview with the SIC on 01/17/24 at 4:25pm revealed he thought the two residents in the television room did not exit during the fire drill because he did not "go around and tell them to go outside because it was a fire drill". Interview with the SIC on 01/18/24 at 4:15pm revealed: -Resident #3 would take up to a half an hour in the bathroom. -He had to help push or pull Resident #3 out of the bathroom when he was in his wheelchair. -Resident #3 did not exit the building during the fire drill because he was weak today, 01/18/24. Attempted telephone interviews with Resident #3's primary care provider (PCP) on 01/18/24 at 12:38pm and 2:33pm were unsuccessful. Attempted telephone interviews with the Administrator on 01/17/23 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful.	C 022		

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C 022	Continued From page 12 The facility failed to ensure the building was equipped and maintained in accordance with the facility's license capacity to allow 1 of 4 residents living in the facility who had a physical limitation and utilized a wheelchair (#3) to evacuate the facility independently in case of an emergency such as a fire. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 01/19/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2024.	C 022		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to maintain an	C 078	Exterminator was hired on Feb 7th and will be returning on Feb 28th. Administrator also did a detailed cleaning of the community.	2/7/24

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RIISING 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 078	Continued From page 13 environment that was clean and free from hazards as evidenced by an active infestation of roaches throughout the facility. The findings are: Review of the most recent Environmental Health report dated 08/14/23 for the facility revealed: -The facility received a a demerit score of 11 and a status code of an A. -Six points were deducted for vermin control. -There was an additional note under observations, "Observed roaches in the kitchen." Observation of the Supervisor-in-Charge (SIC) on 01/17/24 at 8:31am revealed he raised his leg and used the bottom of his shoe to kill a live cockroach crawling on the edge of the dining room table. Observations of the facility on 01/17/24 at various times from 8:47am to 12:32pm revealed: -At 8:47am, a live cockroach was observed running up the wall above the stove in the kitchen and ran under the ventilation fan; a second cockroach was observed in the cabinet that stored applesauce and pudding cups and a third cockroach ran up the cabinet between two doors near the stove. -At 9:00am, there were two dead cockroaches observed on the floor in the hallway. -At 9:02am, there was a dead cockroach on the dresser in a resident's room. -At 12:32pm, a live cockroach walked on the floor beside the kitchen table. Observations of the facility on 01/18/24 at various times between 9:08am to 3:50pm revealed: -At 9:08am, a live cockroach crawled on the dining room table.	C 078		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER RISING HOPE HEALTH CARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 233 GHOLSON AVENUE HENDERSON, NC 27536		
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C 078	Continued From page 14 -At 10:20am, more than eight live cockroaches of various sizes were observed running up the insides, across the lid and down the outside of the trash can when the lid was opened. -At 3:06pm, a live cockroach was crawling up the wall closest to the dining room table and a second live cockroach was crawling up the wall next to the stove. -At 3:48pm, a live cockroach crawled across the dining room table. -At 3:50pm, a live cockroach crawled across the dining room floor. Interview with a resident on 01/17/24 at 9:02am revealed: -He saw two to three live cockroaches every day in his room. -He had seen a live cockroach in the kitchen two days ago. -He was seeing more cockroaches in more places inside lately. -The pest control company came and sprayed about every three months. -He would see dead or dying cockroaches after the pest control company came. -He had seen cockroaches on his personal belongings; he had seen them on his dresser this week. Interview with a second resident on 01/17/24 at 9:21am revealed: -He had seen cockroaches crawling on the floor in his room; the last time was a few days ago. -He saw live cockroaches in the facility three to four times a week. -He had seen a cockroach crawling on the floor in the kitchen a couple of days ago. -The SIC saw the cockroaches too because he stepped on them and killed them when he saw them.	C 078			

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NAME OF PROVIDER OR SUPPLIER RISING HOPE HEALTH CARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 233 GHOLSON AVENUE HENDERSON, NC 27536
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C 078	Continued From page 15 -The pest control company came about once a month, but he did not recall the last time they were at the facility. Interview with a third resident on 01/17/24 at 1:07pm revealed: -He saw cockroaches everywhere in the facility. -The cockroaches started in the kitchen and moved around to the rest of the facility. -He had seen cockroaches in his room on his personal items and on his nightstand. -He had found them in his bed. -He had found one crawling on him in his sleep the night before; he felt something weird on him and found the live cockroach. -He told the SIC about the cockroaches in his room and on his bed and the SIC told him they were spraying for them. -He had seen an exterminator spray for bugs about six months ago, but they had gotten worse since then. Interview with the SIC on 01/17/24 at 8:31am and 12:09pm revealed: -There was only a cockroach issue from time to time and a pest control came by to spray the facility. -He did not know how often the pest control company exterminated the facility. -The pest control company had been to the facility about two months ago and sprayed for bugs. -He did not know the name of the pest control company. -The Administrator had any pest control reports and was currently out of the state. Interview with the SIC on 01/18/24 at 1:55pm revealed: -The residents did not report seeing cockroaches	C 078		

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C 078	Continued From page 16 to him. -The residents never complained about cockroaches because from time to time they saw the pest control company in the facility. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. The facility failed to ensure the kitchen, dining room and resident rooms were kept clean and free of hazards resulting in the evidence of live and dead cockroaches on walls, in food storage cabinets, on trash cans, floors, in residents' rooms and on the residents' personal belongings. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/05/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2024.	C 078		
C 100	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members	C 100	Administrator shall submit copies of fire drill rehearsals annually to the County Department of Social	

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C 100	Continued From page 17 present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuated the facility without verbal prompting and physical assistance resulting in two residents who did not respond to the fire drill. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents. Observation of the facility on 01/17/24 at 8:30am revealed 4 residents resided in the facility. Review of the facility's fire rehearsal schedule revealed: -On 01/01/23 at 6:30 (am/pm were not indicated), all residents were directed to the front of the building for safety; the evacuation time was two minutes. -On second shift on 01/01/23 there was documentation the same procedure was taken to ensure patient safety; the evacuation time was one and a half minutes and all residents were moved to the back of the building "since the fire was coming from the front". -On 06/01/23 at 4:00am all residents were asked to move to the front of the building for safety by the Administrator and the staff; the evacuation time was one and a half minutes.	C 100	Services.	

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C 100	Continued From page 18 -On second shift on 06/01/23, no time was documented, all residents were ordered to the front of the building for safety; the evacuation time was one minute and 45 seconds. Observation of a fire drill on 01/17/24 from 4:21pm to 4:25pm revealed: -There were three residents present during the fire drill; one resident was seated outside on the front porch. -One resident was in his room with the door closed and two residents were seated in the television room watching television including Resident #3 who was sitting in his wheelchair. -At 4:21pm, the Supervisor-in-Charge (SIC) set off the fire alarm at a control panel; a loud alarm sounded with a flashing light in the hallway near the television room and at the entrance to the facility. -At 4:24pm, the resident in his room exited the facility and stayed on the porch. -The two residents in the television room remained seated and did not exit the facility during the fire drill. -At 4:25pm the SIC turned off the fire alarm. Interview with a resident on 01/17/24 at 12:36 PM revealed: -They had a fire drill about five months ago; he thought the fire department was at the facility at the last fire drill. -The Administrator pulled the alarm and then said "fire" and told the residents to go outside. -The residents meet on the front porch. Second interview with a resident on 01/17/24 at 4:25pm revealed: -He did not exit the facility when he heard the fire alarms because he thought the SIC was only testing the alarm.	C 100		

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C 100	Continued From page 19 -The SIC did not announce there was going to be a fire drill and did not tell him to get out during the drill, so he did not leave. -The Administrator was not there, and the Administrator told him to leave when there was a fire drill. Interview with a second resident on 01/17/24 at 1:07pm revealed: -The last fire drill was about 10 months ago. -He thought the fire alarm company was at the facility with the Administrator and they turned on the alarm. -The only time they had fire drills was when the fire alarm company came to the facility; they did not do routine fire drills. -Sometimes the Administrator would give a verbal notice before they turned on the fire alarm. -When they turned on the fire alarm the Administrator would make sure the residents got outside. -The Administrator would say "fire drill" or "we got to go outside". Interview with a third resident on 01/17/24 at 4:28pm revealed: -He did what everyone else did during a fire drill; no one left this time. -There had not been a fire drill without the staff announcing one. -He did not exit the facility when the fire alarm sounded because he was seated in his wheelchair. -Staff helped him during a fire drill by pushing him out of the facility. Interviews with the SIC on 01/17/24 at 9:49 AM and 12:14pm revealed: -During a fire drill, the Administrator ordered everyone out.	C 100		

Division of Health Service Regulation

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C 100	Continued From page 20 -The Administrator would activate the alarm and then order all the residents to get out. -He did not know if the fire drills were documented; he did not document the fire drills. -The Administrator told him he wanted everyone out of the facility by a certain time but was not specific about the time. -He was not sure how long the fire drills took. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. The facility failed to ensure fire drills were conducted appropriately to ensure two residents knew to respond to a fire alarm and exit the facility without being verbally prompted to do so. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/17/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2024.	C 100		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting	C 185		

Division of Health Service Regulation

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C 185	Continued From page 21 and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules for family care homes related to the Supervisor-in-Charge (SIC) not being able to contact the Administrator during his extended absence resulting in the SIC being unable to locate information related to the facility and resident care. The findings are: Observations of the facility during the initial tour on 01/17/24 at 8:30am revealed: -Four residents resided in the facility. -There was one staff; a SIC who resided on the second floor of the facility. Observation of the SIC on 01/17/24 at 1:39pm revealed: -He used a resident's personal cell phone to attempt to call the Administrator. -The call went to a voicemail box that was full and would not allow a message to be left. Interview with the SIC on 01/17/24 at 8:27am	C 185	Administrator shall maintain an open line of communication with SIC. Making sure he is reachable at all times of the day in case of any concerns need to be addressed. Administrator and SIC shall ensure all information relating to the facility and care of residents are maintained at the facility and accessible to both the administrator and SIC.	2/7/24

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C 185	Continued From page 22 revealed: -He resided at the facility on the second floor. -The Administrator had been out of the state for a couple of weeks. -The last time the Administrator was at the facility was sometime around the middle of December 2023. -The Administrator visited the facility about once a week to deliver groceries. -He could not locate requested documents for the facility and residents' records because only the Administrator had access to them. -The SIC could not reach the Administrator by cell phone because he did not have the Administrator's current cell phone number when he left the state. -He had contacted the Administrator via an application (app) on his personal cell phone, but he was not responding to him through the cell phone app today, 01/17/24. -He did not know when the Administrator would be returning from being out of the state. Interviews with a resident on 01/17/24 at 12:32pm and 1:39pm revealed: -The last time he had seen the Administrator at the facility was 12/01/23. -The Administrator usually visited the facility about once a week or twice a month. -He had the Administrator's cell phone number, but he had not attempted to contact him in a while. Interview with a second resident on 01/17/24 at 1:22pm revealed: -The last time he had seen the Administrator in the facility was in December 2023. -The Administrator usually visited the facility about once a month or as needed. Interviews with the SIC on 01/17/24 at various	C 185			

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C 266	Continued From page 36 11:45am revealed the residents were served a bologna and cheese sandwich on whole wheat bread, potato chips, pudding cups and water. Observation of the dinner meal on 01/17/24 from 4:41pm to 5:00pm revealed the residents were served a chicken patty on a bun, a tomato wedge, green beans and water. Observation of the lunch meal on 01/18/24 at 12:10pm revealed the residents were served two hot dogs on buns, potato chips and water. Review of the facility's menu substitution log on 01/17/24 at 12:34pm and on 01/18/24 at 2:06pm revealed: -The last time the menu substitution log was completed was 09/12/23. -There were no substitutions documented for the lunch or dinner meals served on 01/17/24. -There were no substitutions documented for the lunch meal on 01/18/24. Interview with the Supervisor-in-Charge (SIC) on 01/17/24 at 12:30pm revealed: -He substituted items on the menu because he did not have the items to serve or the residents requested different or special menu items. -He substituted items from the menu about three times or meals a week. -He wrote down the substituted items on the substitution log. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful.	C 266		
C 270	10A NCAC 13G .0904 (c)(7) Nutrition And Food Service	C 270		

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C 185	Continued From page 23 times between 8:31am and 12:09pm revealed: -The Administrator had been out of the state for a couple of weeks. -The SIC did not know how often the pest control company exterminated the facility and he did not know the name of the pest control company. -The Administrator contacted the pest control company, he had any pest control reports and was currently out of the state. -He did not know where the fire drill logs were kept because the Administrator had them. -He thought a fire drill had been done recently but he was not sure when. -The Administrator conducted the fire drills and he participated. -An outside organization had done a fire drill with the Administrator, but he was not sure who the agency was. -He did not know how to conduct a fire drill or how to activate the alarm because he had never been shown. -He substituted items on the menu because he did not have the items from the menu to serve. -The Administrator purchased groceries once a week based on the list the SIC provided him. -The last time groceries had been delivered was Tuesday a week ago, one of the Administrator's family members delivered the groceries. -He did not know about any scheduled appointments for the residents; the Administrator would tell him when they had appointments. -The Administrator scheduled physician appointments. -The Administrator arranged for the residents' transportation through a transportation company to physician appointments; he did not schedule transportation. Interviews with the SIC on 01/18/24 at various times between 8:30am to 3:00pm revealed:	C 185		

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C 185	Continued From page 24 -The Administrator had seen him place medication cups for the residents at meal times. -He did not do anything with the resident care plans; the Administrator was responsible for them. -He did not know anything about LHPS evaluations for residents; the Administrator was responsible for them. -He would lock the refrigerator at the end of the day by snapping it closed; the black storage box with the residents' injectable pens was never locked because he did not know the combination. -He did not have anything to do with the pharmacy reviews; the Administrator did them -He did not have a diabetic menu to follow as guidance when preparing meals. -The Administrator had not provided him with a therapeutic diet menu. -He was not aware a resident had a physician's ordered therapeutic diet; he did not know what an ADA diet was. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. The Administrator failed to ensure the overall management, operations, and policies of the facility were implemented by failing to ensure the Supervisor-in-Charge (SIC) was able to contact the Administrator during the Administrator's extended absence; the SIC did not have access to resident care plans and other documents, therapeutic diet menus or contact information for the pest control company, was unable to schedule transportation for residents to appointments, was unable to contact the pharmacy, or purchase foods for the residents based on the weekly menu, and make decisions as needed without the guidance of the	C 185			

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NAME OF PROVIDER OR SUPPLIER RISING HOPE HEALTH CARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 233 GHOLSON AVENUE HENDERSON, NC 27536		
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C 185	Continued From page 25 Administrator in his absence. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a B Violation. The facility failed to submit the plan of protection in accordance with G.S. 131D-34 on 02/05/24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2024.	C 185			
C 240	10A NCAC 13G .0802(e) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 3 residents (#1, #2, #3) had completed resident assessment signed by the physician within 15 days of assessment. The findings are: 1. Review of Resident #1's current FL2 dated 10/24/23 revealed diagnoses included hypertension, hyperlipidemia, chronic leg ulcer and atrial fibrillation.	C 240			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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C 240	Continued From page 26 Review of Resident #1's Resident Register revealed there was no admission date documented. Review of Resident #1's care plan revealed: -The box on the top right-hand corner of the care plan was not filled out and was not dated. -There were no dates on the first page. -The Administrator had signed and dated the care plan on 06/01/23. -There was a physician's signature, but it was not dated. Attempted telephone interviews with Resident #1's primary care provider (PCP) on 01/18/24 at 12:38pm and 2:33pm were unsuccessful. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. Refer to interview with the supervisor-in-charge (SIC) on 01/18/24 at 1:23pm. 2. Review of Resident #2's current FL2 dated 12/20/23 revealed diagnoses included hypertension, hyperlipidemia, schizophrenia and type two diabetes. Review of Resident #2's Resident Register revealed an admission date of 11/10/14. Review of Resident #2's care plan revealed: -The box on the top right-hand corner of the care plan was not filled out and was not dated. -There were no dates on the first page. -The Administrator had signed and dated the care plan on 06/01/23. -There was a physician's signature, but it was not dated.	C 240		

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C 240	Continued From page 27 Attempted telephone interviews with Resident #1's primary care provider (PCP) on 01/18/24 at 12:38pm and 2:33pm were unsuccessful. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. Refer to interview with the supervisor-in-charge (SIC) on 01/18/24 at 1:23pm. 3. Review of Resident #3's current FL2 dated 10/24/23 revealed diagnoses included hypertension, hyperlipidemia, schizophrenia and hypothyroidism. Review of Resident #3's Resident Register revealed an admission date of 07/30/15. Review of Resident #3's care plan revealed: -The box on the top right-hand corner of the care plan was not filled out and was not dated. -There were no dates on the first page. -The Administrator had signed and dated the care plan on 06/01/23. -There was a physician's signature, but it was not dated. Attempted telephone interviews with Resident #1's primary care provider (PCP) on 01/18/24 at 12:38pm and 2:33pm were unsuccessful. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. Refer to interview with the supervisor-in-charge (SIC) on 01/18/24 at 1:23pm.	C 240			

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RISING HOPE HEALTH CARE SERVICES

233 GHOLSON AVENUE
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C 240	Continued From page 28 Interview with the supervisor-in-charge (SIC) on 01/18/24 at 1:23pm revealed he did not do anything with the resident care plans; the Administrator was responsible for them.	C 240		
C-246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure follow-up appointments for 1 of 3 sampled residents (#2) with a primary care provider (PCP). The findings are: Review of Resident #2's current FL2 dated 12/20/23 revealed diagnoses included hypertension, hyperlipidemia, schizophrenia and type two diabetes. Review of Resident #2's record revealed an appointment card from his primary care provider's (PCP) office with an appointment scheduled for 12/26/23 at 9:15am. Interviews Resident #2 on 01/17/24 at 12:45pm and 2:31pm revealed: -The last time he visited his PCP was on 12/20/23. -He had blood drawn for lab work at the appointment on 12/20/23. -He had a follow-up appointment scheduled for 12/26/23 but he missed it because no one showed up to take him to the appointment.	C 246	Administrator will ensure that all followups are being completed and inform SIC of any upcoming appointments. An appointment book and/or Calendar shall be kept at facility to ensure followup appointments are met.	2/14/24

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C 246	Continued From page 29 -He thought the appointment on 12/26/23 was to clean out his ears and to discuss the lab results from his bloodwork. -Sometimes he needed his ears cleaned out by the PCP because it affected his hearing. -He did not know if the appointment was rescheduled. -His hearing was fine, and his ears felt fine. Telephone interview with a scheduler from Resident #2's PCP's office on 01/18/24 at 9:55am revealed: -Resident #2 had an appointment scheduled for 9:15am on 12/26/23. -Someone called and canceled the appointment and rescheduled it for 01/03/24. -Resident #2 was a "no show" for the rescheduled appointment on 01/03/24; no one had called to reschedule the missed appointment. -Resident #2 had lab work done on his visit on 12/20/23 and had a follow-up visit scheduled one week later on 12/26/23. Interview with the Supervisor-in-Charge (SIC) on 01/17/24 at 3:00pm revealed: -The Administrator scheduled physician appointments. -The Administrator arranged for the residents' transportation to physician appointments. -He did not know about any appointments for Resident #2. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful.	C 246			
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support	C 254			

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C 254	Continued From page 30 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, 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 30 days after admission or within 30 days from the date 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 a Licensed Health Professional Support (LHPS) was completed within 30 days from the date the resident developed the need for the task and quarterly thereafter for 3 of 3 sampled residents (#1, #2 and #3) with LHPS tasks of medication administration through injection (#1, #2) and ambulation using an assisted device (#3). The findings are: 1. Review of Resident #1's current FL2 dated	C 254		

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RISING HOPE HEALTH CARE SERVICES

**233 GHOLSON AVENUE
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C 254	Continued From page 31 10/24/23 revealed: -Diagnoses included hypertension, hyperlipidemia, chronic leg ulcer and atrial fibrillation. -There was not an order for Ozempic (used to treat diabetes) .75 mL/1mg once weekly. Review of Resident #1's November 2023, December 2023 and from 01/01/24 to 01/17/24 medication administration record (MAR) revealed: -There was an electronic entry for Ozempic .75 mL/1mg inject once weekly scheduled at 8:00am. -Ozempic .75 mL/1mg was documented as administered on 11/04/23, 11/10/23, 11/17/23 and 11/23/23, 12/08/23, 12/22/23, 12/30/23, 01/05/24 and 01/12/24. Review of Resident #1's LHPS evaluations revealed there was no LHPS evaluation available for review. Interview with Resident #1 on 01/18/24 at 12:54pm revealed: -He was diagnosed with prediabetes about four to six months ago and he was ordered the Ozempic injection once weekly. -The Supervisor-in-Charge (SIC) gave him his weekly injection of Ozempic. Interview with the SIC on 01/18/24 at 1:23pm revealed: -He did not know anything about LHPS evaluations for residents; the Administrator was responsible for them. -He gave Resident #1 his weekly injection of Ozempic. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful.	C 254		

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C 254	Continued From page 32 2. Review of Resident #2's current FL2 dated 12/20/23 revealed: -Diagnoses included hypertension, hyperlipidemia, schizophrenia and type two diabetes. -There was an order for Novolog (used to treat type 2 diabetes) 20 units inject twice daily. Review of Resident #2's November 2023, December 2023, and from 01/01/24 to 01/17/24 medication administration record (MAR) revealed: -There was an electronic entry for Novolog 20 units before breakfast and dinner and 15 units before lunch scheduled at 7:30am, 11:30am and 4:30pm. -Novolog 20 units was documented as administered 60 of 60 opportunities from 11/01/23 to 11/30/23. -Novolog 15 units was documented as administered 30 of 30 opportunities from 11/01/23 to 11/30/23. -Novolog 20 units were documented as administered 62 of 62 opportunities from 12/01/23 to 12/31/23. -Novolog 15 units were documented as administered 31 of 31 opportunities from 12/01/23 to 12/31/23. -Novolog 20 units were documented as administered 28 of 34 opportunities from 01/01/24 to 01/17/24. -Novolog 15 units were documented as administered 14 of 17 opportunities from 01/01/24 to 01/17/24. Review of Resident #2 LHPS evaluations revealed: -The most current LHPS evaluation was dated 10/12/22. -Tasks included medication administration	C 254		

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C 254	Continued From page 33 through injection. -Staff had been trained on insulin injections. -There was documentation on the LHPS evaluation that the next assessment would be done on 10/11/23. -There were no other LHPS evaluations in Resident #2's record. Interview with Resident #2 on 01/17/24 at 1:43pm revealed: -He administered his own Novolog three times a day; 20 units before breakfast and dinner and 15 units before lunch time. -He attended a day program and took a Novolog pen with him to his day program so he could administer his Novolog while at the program. Interview with the SIC on 01/18/24 at 1:23pm revealed: -He did not know anything about LHPS evaluations for residents; the Administrator was responsible for them. -Resident #2 injected his own Novolog. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. 3. Review of Resident #3's current FL2 dated 10/24/23 revealed: -Diagnoses included hypertension, hyperlipidemia, schizophrenia and hypothyroidism. -He was semi-ambulatory; no assistive device was listed. Review of Resident #3's assessment and care plan revealed: -The Administrator signed and dated the care plan on 06/01/23.	C 254			

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C 254	Continued From page 34 -The resident was ambulatory with aid or device; the device was not listed. -The resident had limited range of motion in his upper extremities. -The resident was totally dependent for toileting, transferring, eating, dressing, bathing, and grooming. -There was no documentation for the level of assistance needed for ambulation/locomotion. Observations of Resident #3 on 01/17/24 at 8:30am revealed Resident #3 was sitting in a wheelchair in the television room. Review of Resident #3's LHPS evaluations revealed there was no LHPS evaluations available for review. Interview with Resident #3 on 01/17/24 at 11:05am revealed: -He had gotten weaker in the last six months. -He had fallen before he got the wheelchair, but he had not fallen since. -He had the wheelchair for about six months. -The Administrator gave him the wheelchair. Interview with the Supervisor-in-Charge (SIC) on 01/18/24 at 1:23pm revealed: -He did not know anything about LHPS evaluations for residents; the Administrator was responsible for them. -The Administrator gave Resident #3 the wheelchair because he could not always walk. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful.	C 254			

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C 266	Continued From page 35	C 266	Administrator and SIC 7/7/24. Shall make sure any Substitutions made to menu has equal nutritional value and documentation of any substitutions shall be maintained in Records for the facility		
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 of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen 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 of equal nutritional value and documented to indicate the foods served to the residents. The findings are: Review of the facility's weekly menu for the week of 01/14/24 revealed: -The weekly menu ran from Sunday to Saturday. -The lunch meal for Wednesday, 01/17/24, was vegetable juice, tuna salad, two whole wheat slices of bread, and unsweetened peaches, water and unsweetened iced tea. -The dinner meal for Wednesday, 01/17/24 was stewed chicken with rice, carrots, angel food cake, water and unsweetened iced tea. -The lunch meal for Thursday, 01/18/24 was a turkey sandwich on whole wheat bread with lettuce and tomato, a fresh apple and water. Observation of the lunch meal on 01/17/24 at	C 266			

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C 270	Continued From page 37 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure matching therapeutic diet menus were available for 1 of 3 sampled residents who was ordered an American Diabetes Association (ADA) diet (#2). Review of the facility's weekly menu posted in the kitchen for the week of 01/14/24 revealed: -The weekly menu ran from Sunday to Saturday. -The lunch meal for Wednesday, 01/17/24, was vegetable juice, tuna salad, two whole wheat slices of bread, unsweetened peaches, water and unsweetened iced tea. -The dinner meal for Wednesday, 01/17/24 was stewed chicken with rice, carrots, angel food cake, water and unsweetened iced tea. Review of Resident #2's current FL2 dated 12/20/23 revealed: -Diagnoses included hypertension, hyperlipidemia, schizophrenia and type two diabetes. -There was an order for an ADA diet. Observation of the kitchen on 01/17/24 at 8:47am revealed there was no therapeutic diet menu available for the staff to reference while preparing the residents' meals.	C 270	Administrator and SIC shall make sure facility have therapeutic diet menus to match physicians orders	

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NAME OF PROVIDER OR SUPPLIER RISING HOPE HEALTH CARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 233 GHOLSON AVENUE HENDERSON, NC 27536		
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C 270	Continued From page 38 Observation of the lunch meal on 01/17/24 at 11:45am revealed the residents were served a bologna and cheese sandwich on whole wheat bread, potato chips, pudding cups and water. Observation of the dinner meal on 01/17/24 from 4:41pm to 5:00pm revealed the residents were served a chicken patty on a bun, a tomato wedge, green beans and water. Interview with Resident #2 on 01/17/24 at 9:21am revealed: -He had diabetes. -He was provided sugar free desserts and artificial sweetener for his coffee and cereal. -He was not ordered a special diet by his physician. Interview with the Supervisor-in-Charge (SIC) on 01/18/24 at 2:04pm revealed: -He did not have a diabetic menu to follow as guidance when preparing meals. -The Administrator had not provided him with a therapeutic diet menu. -He followed the weekly menu that was posted on the wall when preparing meals for Resident #2. -He was not aware Resident #2 had a physician's ordered therapeutic diet; he did not know what an ADA diet was. Attempted telephone interviews with Resident #1's primary care provider (PCP) on 01/18/24 at 12:38pm and 2:33pm were unsuccessful. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful.	C 270			

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STREET ADDRESS, CITY, STATE, ZIP CODE

RISING HOPE HEALTH CARE SERVICES

**233 GHOLSON AVENUE
HENDERSON, NC 27536**

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C 273	Continued From page 39	C 273		
C 273	10A NCAC 13G .0904(d)(3) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family 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, at no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents were served one and a half cups of fruit daily and two cups of vegetables as recommended based on the U.S. Department of Agriculture Dietary Guidelines for Americans. The findings are: Review of the U.S. Department of Agriculture Dietary Guidelines for Americans 2020-2025 revealed: -Adults aged 19-59 and 60+ should consume a minimum of 1 1/2 cups of fruit daily for a 1600-calorie diet and up to 2 cups for higher caloric diets. -The fruit food group included whole fruits and 100% fruit juice.	C 273		

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C 273	Continued From page 40 -Whole fruits included fresh, canned, frozen, and dried forms. -Whole fruits could be eaten in various forms, such as cut, sliced, diced, or cubed. -At least half of the recommended amount of fruit should come from whole fruit, rather than 100% juice. -When juices were consumed, they should be 100% juice and always pasteurized or 100% juice diluted with water (without added sugars). -Adults aged 19-59 and 60+ should consume a minimum of 2 cups of vegetables a day for a 1600-calorie diet. -The vegetable group included dark green leafy vegetables, red and orange vegetables, beans, peas, lentils and starchy vegetables. Observation of the food storage areas in the facility on 01/17/24 at 8:45am revealed: -There was a single up right refrigerator in the kitchen; the freezer was on top. -There was an opened package of bologna, three fresh tomatoes, and a one-gallon jug of fruit juice that had less than 1/4 remaining in the refrigerator. -There were four packages of eight count hot dogs in the freezer and a loaf of whole wheat bread on top. -There was a large unopened bag of potato chips in a cabinet. -There was a package of 36 pre-portioned pudding cups and an open box of pre-portioned applesauce cups in a cabinet. -There was a small deep chest freezer with nine packages hot dogs; there were eight hot dogs per pack. -There was a 1 pound package of bologna, half a bag of breaded chicken patties, a two-pound bag of meatballs and half a bag of French fries. -There was a second refrigerated located on the	C 273		

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C 273	Continued From page 41 upstairs floor of the facility; the freezer was on top. -There were six loaves of whole wheat bread, eight packages of eight count hot dog buns and six packages of eight count hamburger buns. -There was three fourths of a case of hamburger patties in the freezer. Review of the facility's weekly menu posted in the kitchen for the week of 01/14/24 revealed: -The weekly menu ran from Sunday to Saturday. -The lunch meal for Wednesday, 01/17/24, was vegetable juice, tuna salad, two whole wheat slices of bread, unsweetened peaches, water and unsweetened iced tea. -The dinner meal for Wednesday, 01/17/24 was stewed chicken with rice, carrots, angel food cake, water and unsweetened iced tea. -The lunch meal for Thursday, 01/18/24 was a turkey sandwich on whole wheat bread with lettuce and tomato, a fresh apple and water. Observation of the lunch meal on 01/17/24 at 11:45am revealed the residents were served a bologna and cheese sandwich on whole wheat bread, potato chips, pudding cups and water. Observation of the dinner meal on 01/17/24 from 4:41pm to 5:00pm revealed the residents were served a chicken patty on a bun, a tomato wedge, green beans and water. Observation of the lunch meal on 01/18/24 at 12:10pm revealed the residents were served two hot dogs on buns, potato chips and water. Interview with a resident on 01/17/24 at 9:02am revealed: -He could stand more of a variety of foods. -He could not stand the same foods that were	C 273			

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C 273	Continued From page 42 served week after week; he needed more taste. -He was served fruit a couple of times a week and it was always apple sauce cups. -He was served vegetables about three times a week and it was always green beans. -They were served a lot of hot dogs. -He was served bologna sandwiches more than two times a week. -He was not served juice to drink. -Breakfast was the best meal because the residents were served cereal, eggs, grits and sausage links. Interview with a second resident on 01/17/24 at 9:21am and 12:36pm revealed: -He was served chicken patties on a bun, pinto beans, green beans, bologna sandwiches and hot dogs a lot. -He had never requested bologna sandwiches or hot dogs; that was just what was served all the time. -He was served bologna sandwiches and hot dogs a couple of times a week. -He would like more vegetables like collard greens; something other than green beans would be good. -He was served a tomato wedge occasionally. -They had fresh bananas about one or two weeks ago. -He was served apple sauce one to two times a week. -He would eat more variety of fruit if it was offered but it was never offered. -He purchased his own fruit juice because the Administrator told him to buy it himself if he wanted it to drink. -He drank milk with his cereal in the morning. Interview with a third resident on 01/17/24 at 12:52pm revealed:	C 273		

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C 273	Continued From page 43 -They were not offered a variety of food. -Sometimes he got tired of what he was served; basically, it was the same food over and over. -The residents were served hot dogs two times a week and bologna sandwiches for lunch, but he did not know how often. -The residents were served a lot of hot dogs, bologna sandwiches, pinto beans, and green beans. -He was served pudding or applesauce for desserts. -The last time he had fresh fruit was bananas a few weeks ago; he would eat fruit if it was served. -He would like leafy green vegetables and something other than green beans. -He would like to drink fruit juice but it was not offered. -Some of the residents bought their own drinks. Interview with the Supervisor-in-Charge (SIC) on 01/17/24 at 8:47am and 12:30pm revealed: -The Administrator had been out of the state for a couple of weeks. -The Administrator purchased groceries once a week based on the list the SIC provided him. -The last time groceries had been delivered was Tuesday a week ago, and the next delivery would be on Monday of the following week. -He substituted items on the menu because he did not have the items to serve or the residents requested different or special menu items. -He substituted items from the menu about three times or three meals a week. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful.	C 273			

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C 330	Continued From page 44	C 330	Administrator Shall ensure that SIC is following and preparing medications as they are ordered. SIC shall ask for Clarification if there is any questions about an order. Administrator shall get all physician's orders are Clarified and followed as ordered. SIC shall follow all physician's orders.	2/13/24
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 sampled residents (#1, #2, #3) related to two high blood pressure medications, a diuretic, a low potassium medication, a high cholesterol medication, and an anti-diabetic medication (#1), a high blood pressure medication, an anti-tremor medication, two high cholesterol medications, a glaucoma medication, an insulin injection, an anti-diabetic medication, and an antipsychotic medication (#2), two high blood pressure medications, an anticonvulsant, and a glaucoma medication (#3). The findings are: 1. Review of Resident #1's current FL2 dated 10/24/23 revealed diagnoses included hypertension, hyperlipidemia, chronic leg ulcer and atrial fibrillation. a. Review of Resident #1's current FL2 dated 10/24/23 revealed there was an order for metoprolol (used to treat high blood pressure)	C 330		

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C 330	Continued From page 45 100mg one tablet twice daily. Review of Resident #1's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for metoprolol 100mg take two tablets daily; there was only one scheduled administration time at 8:00am. -Metoprolol 100mg was documented as administered once daily, 30 of 30 opportunities from 11/01/23 to 11/30/23. Review of Resident #1's December 2023 MAR revealed: -There was an electronic entry for metoprolol 100mg take two tablets every day; there was only one scheduled administration time at 8:00am. -Metoprolol 100mg was documented as administered once daily, 31 of 31 opportunities from 12/01/23 to 12/31/23. Review of Resident #1's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was an electronic entry for metoprolol 100mg take two tablets every day; there was only one scheduled administration time at 8:00am. -Metoprolol 100mg was documented as administered once daily, 16 of 17 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. Observation of Resident #1's medication on hand on 01/18/24 at 10:20am revealed: -There was an empty medication card dispensed on 12/15/23 for metoprolol 100mg. -There was a pharmacy label on the empty card of metoprolol with Resident #1's name and the instructions to administer two tablets once daily; 60 tablets were dispensed. -There were no other metoprolol tablets available for administration for Resident #1.	C 330		

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C 330	Continued From page 46 Telephone interview with the pharmacist from the facility's contracted pharmacy on 01/18/24 at 12:13pm revealed: -Resident #1's current FL2 dated 10/24/23 had not been sent to the pharmacy. -The most recent order the pharmacy had for Resident #1's metoprolol 100mg was take two tablets once daily was dated 07/12/23. -A thirty-day supply of sixty tablets of metoprolol 100mg had been dispensed on 11/15/23, 12/15/23 and 01/13/23. -Metoprolol was used to treat high blood pressure. Interview with Resident #1 on 01/18/24 at 12:54pm revealed: -He thought he was ordered metoprolol once a day but that was all he knew. -He gave all his papers from his physicians' appointment to the Supervisor-in-Charge (SIC). -He did could not identify all his medications when they were administered to him. -He took the medications that were in his medication cup. b. Review of Resident #1's current FL2 dated 10/24/23 revealed there was an order for torsemide (used to treat fluid retention) 20mg two tablets daily. Review of Resident #1's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for torsemide 20mg take one tablet twice daily; there was only one time scheduled at 8:00am. -One tablet of torsemide 20mg was documented as administered once daily, 30 of 30 opportunities from 11/01/23 to 11/30/23.	C 330		

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C 330	Continued From page 47 Review of Resident #1's December 2023 MAR revealed: -There was an electronic entry for torsemide 20mg take one tablet twice daily; there was only one time scheduled at 8:00am. -One tablet of torsemide 20mg was documented as administered once daily, 31 of 31 opportunities from 12/01/23 to 12/31/23. Review of Resident #1's January 2024 MAR from 01/01/24 to 01/17/24 revealed: -There was an electronic entry for torsemide 20mg take one tablet twice daily; there was only one time scheduled at 8:00am. -One tablet of torsemide 20mg was documented as administered once daily, 16 of 17 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. Observation of Resident #1's medication on hand on 01/18/24 at 10:20am revealed: -There were five medication cards with torsemide 20mg administer one tablet twice daily. -Sixty tablets of torsemide 20mg were dispensed on 11/15/23 on a card labeled 2 of 3; 60 tablets were available for administration. -Sixty tablets of torsemide 20mg were dispensed on 11/15/23 on a card labeled 3 of 3; 60 tablets were available for administration. -Sixty tablets of torsemide 20mg were dispensed on 12/15/23 on a card labeled 1 of 3; 60 tablets were available for administration. -Sixty tablets of torsemide 20mg were dispensed on 12/15/23 on a card labeled 2 of 3; 42 tablets were available for administration. -Sixty tablets of torsemide 20mg were dispensed on 12/15/23 on a card labeled 3 of 3; 60 tablets were available for administration. -There was a total of 282 tablets of torsemide 20mg available for administration.	C 330			

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C 330	Continued From page 48 Telephone interview with the pharmacist from the facility's contracted pharmacy on 01/18/24 at 12:13pm revealed: -Resident #1's current FL2 dated 10/24/23 had not been sent to the pharmacy. -The most recent order the pharmacy had for Resident #1's torsemide was 20mg one tablet twice daily dated 10/13/23. -A thirty-day supply of torsemide was dispensed on 10/12/23 and a ninety-day supply was dispensed on 11/15/23 and 12/15/23. -Torsemide was a diuretic used to treat edema when it was related to heart failure. Interview with Resident #1 on 01/18/24 at 12:54pm revealed: -He knew he was ordered torsemide for fluid retention twice a day. -He had edema in his legs and leg wounds, and it helped with both. -He was currently being treated at a wound care clinic for his leg wounds due to edema. -He did could not identify all his medications when they were administered to him. -He took the medications that were in his medication cup. c. Review of Resident #1's current FL2 dated 10/24/23 revealed there was an order for potassium chloride (used to treat and prevent low potassium levels) 20meq two tablets four times daily. Review of Resident #1's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for potassium chloride 20meq take two tablets twice daily scheduled at 8:00am and 8:00pm. -Two tablets of potassium chloride 20meq twice	C 330			

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C 330	Continued From page 49 daily were documented as administered 30 of 30 opportunities from 11/01/23 to 11/30/23. Review of Resident #1's December 2023 MAR revealed: -There was an electronic entry for potassium chloride 20meq take two tablets twice daily scheduled at 8:00am and 8:00pm. -Two tablets of potassium chloride 20meq twice daily were documented as administered 31 of 31 opportunities from 12/01/23 to 12/31/23. Review of Resident #1's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was an electronic entry for potassium chloride 20meq take two tablets twice daily scheduled at 8:00am and 8:00pm. -Two tablets of potassium chloride 20meq twice daily were documented as administered 16 of 17 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. Observation of Resident #1's medication on hand on 01/18/24 at 10:20am revealed: -There were eight medication cards with potassium chloride 20meq administer two tablets twice daily. -Thirty tablets of potassium chloride 20meq were dispensed on 08/07/23 labeled 2 of 4; 30 tablets were available for administration. -Thirty tablets of potassium chloride 20meq were dispensed on 09/12/23 labeled 1 of 4; 2 tablets were available for administration. -Thirty tablets of potassium chloride 20meq were dispensed on 09/12/23 labeled 2 of 4; 30 tablets were available for administration. -Thirty tablets of potassium chloride 20meq were dispensed on 09/12/23 labeled 4 of 4; 30 tablets were available for administration. -Sixty tablets of potassium chloride 20meq were	C 330			

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C 330	Continued From page 50 dispensed on 12/15/23 labeled 1 of 2; 60 tablets were available for administration. -Sixty tablets of potassium chloride 20meq were dispensed on 12/15/23 labeled 2 of 2; 60 tablets were available for administration. -Sixty tablets of potassium chloride 20meq were dispensed on 01/15/24 labeled 1 of 2; 60 tablets were available for administration. -Sixty tablets of potassium chloride 20meq were dispensed on 01/15/24 labeled 2 of 2; 60 tablets were available for administration. -There was a total of 333 tablets of potassium chloride 20meq available for administration. Telephone interview with the pharmacist from the facility's contracted pharmacy on 01/18/24 at 12:13pm revealed: -Resident #1's current FL2 dated 10/24/23 had not been sent to the pharmacy. -The most recent order the pharmacy had for Resident #1's potassium chloride 20meq administer two tablets twice daily dated 10/13/23. -A thirty-day supply of potassium chloride 20meq was dispensed on 10/15/23, 11/15/23, 12/15/23 and 01/13/24. -Potassium chloride 20meq was used to treat heart failure. Interview with Resident #1 on 01/18/24 at 12:54pm revealed: -He was told by his physician in December 2023 his potassium levels were low. -He was told it was for his heart. -He did could not identify all his medications when they were administered to him. -He took the medications that were in his medication cup. d. Review of Resident #1's current FL2 dated 10/24/23 revealed there was an order for	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/18/2024
NAME OF PROVIDER OR SUPPLIER RISING HOPE HEALTH CARE SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 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 51 atorvastatin (used to treat high cholesterol) 40mg once daily. Review of Resident #1's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for atorvastatin 20mg at bedtime scheduled at 8:00pm. -Atorvastatin 20mg was documented as administered at bedtime, 30 of 30 opportunities from 11/01/23 to 11/30/23. Review of Resident #1's December 2023 MAR revealed: -There was and electronic entry for atorvastatin 20mg at bedtime scheduled at 8:00pm. - Atorvastatin 20mg was documented as administered at bedtime, 31 of 31 opportunities from 12/01/23 to 12/31/23. Review of Resident #1's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was and electronic entry for atorvastatin 20mg at bedtime scheduled at 8:00pm. -Atorvastatin 20mg was documented as administered at bedtime, 16 of 17 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. Observation of Resident #1's medication on hand on 01/18/24 at 10:20am revealed: -There were three medication cards of atorvastatin 20mg administer once daily. -Thirty tablets of atorvastatin 20mg were dispensed on 11/10/23; 30 tablets were available for administration. -Thirty tablets of atorvastatin 20mg were dispensed on 01/08/24; 30 tablets were available for administration. -Thirty tablets of atorvastatin 20mg dispensed on 12/08/23; 16 tablets were available for	C 330			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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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 52 administration -There was a total of 76 tablets of atorvastatin 20mg available for administering. Telephone interview with the pharmacist from the facility's contracted pharmacy on 01/18/24 at 12:13pm revealed: -Resident #1's current FL2 dated 10/24/23 had not been sent to the pharmacy. -Resident #1 had an order for atorvastatin 20mg take one tablet at bedtime dated 10/13/23. -Thirty tablets of atorvastatin 20mg was dispensed for Resident #1 on 11/15/23, 12/15/23 and 01/15/24. -Atorvastatin was used to lower cholesterol in the blood. Interview with Resident #1 on 01/18/24 at 12:54pm revealed: -He was ordered atorvastatin for his heart or blood pressure. -His blood pressures were not taken at the facility. -His primary care provider (PCP) took his blood pressure at his office visits. -He did not know about a change in the order. -He did could not identify all his medications when they were administered to him. -He took the medications that were in his medication cup. e. Review of Resident #1's current FL2 dated 10/24/23 revealed there was not an order for losartan (used to treat high blood pressure) 25mg once daily. Review of Resident #1's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for losartan 25mg once daily scheduled at 8:00am.	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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**233 GHOLSON AVENUE
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C 330	Continued From page 53 -Losartan 25mg was documented as administered 30 of 30 opportunities from 11/01/23 to 11/30/23. Review of Resident #1's December 2023 MAR revealed: -There was an electronic entry for losartan 25mg once daily scheduled at 8:00am. -Losartan 25mg was documented as administered 31 of 31 opportunities from 12/01/23 to 12/31/23. Review of Resident #1's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was and electronic entry for losartan 25mg once daily scheduled at 8:00am. -Losartan 25mg was documented as administered 16 of 17 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. Observation of Resident #1's medication on hand on 01/18/24 at 10:20am revealed there were thirty tablets of losartan 25mg once daily dispensed on 01/13/24; 25 tablets remained in the card. Telephone interview with the pharmacist from the facility's contracted pharmacy on 01/18/24 at 12:13pm revealed: -Resident #1's current FL2 dated 10/24/23 had not been sent to the pharmacy. -Resident #1 had an order for losartan 25mg one tablet once daily dated 08/11/23. -Thirty tablets of losartan 25mg had been dispensed on 11/18/23, 12/15/23, and 01/13/24. -Losartan was used to threat high blood pressure and heart failure. Interview with Resident #1 on 01/18/24 at 12:54pm revealed:	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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C 330	Continued From page 54 -His blood pressures were not taken at the facility. -His PCP took his blood pressure at his office visits. -He did could not identify all his medications when they were administered to him. -He took the medications that were in his medication cup. f. Review of Resident #1's current FL2 dated 10/24/23 revealed there was not an order for Ozempic (used to treat diabetes) 1mg once weekly. Review of Resident #1's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for Ozempic 0.75 mL/1mg inject once weekly scheduled at 8:00am. -Ozempic 0.75 mL/1mg was documented as administered on 11/04/23, 11/10/23, 11/17/23 and 11/23/23. Review of Resident #1's December 2023 MAR revealed: -There was an electronic entry for Ozempic 0.75 mL/1mg inject once weekly scheduled at 8:00am. -Ozempic 0.75 mL/1mg was documented as administered on 12/08/23, 12/22/23, and 12/30/23. Review of Resident #1's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was an electronic entry for Ozempic 0.75 mL/1mg inject once weekly scheduled at 8:00am. -Ozempic 0.75 mL/1mg was documented as administered on 01/05/24 and 01/12/24. Observation of Resident #1's medication on hand on 01/18/24 at 10:20am revealed: -There were two boxes of Ozempic 1mg single	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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C 330	Continued From page 55 dose pens administer once weekly. -Four single dose Ozempic 1mg pens were dispensed on 11/15/23; there was one pen available for administration. -Four single dose Ozempic 1mg pens were dispensed on 12/15/23; there were four pens available for administration. Telephone interview with the pharmacist from the facility's contracted pharmacy on 01/18/24 at 12:13pm revealed: -Resident #1's current FL2 dated 10/24/23 had not been sent to the pharmacy. -Resident #1 had an order for Ozempic 1mg inject once weekly dated 10/10/23. -Four single dose pens were dispensed in a box on 10/13/23, 11/15/23, and 12/14/23. -Ozempic was used to treat for prediabetes and diabetes. Interview with Resident #1 on 01/18/24 at 12:54pm revealed: -He was diagnosed with prediabetes about four to six months ago and he was ordered the Ozempic injection then. -The Supervisor-in-Charge (SIC) gave him his Ozempic injection once a week. Interview with the SIC on 01/18/24 at 1:23am revealed he administered Resident #1 his Ozempic injection once a week. Attempted telephone interviews with Resident #1's primary care provider (PCP) on 01/18/24 at 12:38pm and 2:33pm were unsuccessful. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful.	C 330		

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**233 GHOLSON AVENUE
HENDERSON, NC 27536**

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C 330	Continued From page 56 Refer to interview with the SIC on 01/17/24 at 3:14pm. Refer to interviews with the SIC on 01/18/24 at 10:26am and 1:23pm. 2. Review of Resident #2's current FL2 dated 12/20/23 revealed diagnoses included hypertension, hyperlipidemia, schizophrenia and type two diabetes. a. Review of Resident #2's current FL2 dated 12/20/23 revealed there was an order for atorvastatin (used to treat cholesterol) 40mg at bedtime. Review of Resident #2's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for atorvastatin 40 milligrams once daily scheduled at 8:00am. -Atorvastatin 40mg was documented as administered 30 of 30 opportunities from 11/01/23 to 11/30/23. Review of Resident #2's December 2023 MAR revealed: -There was an electronic entry for atorvastatin 40mg once daily scheduled at 8:00am. -Atorvastatin 40 mg was documented as administered 31 of 31 opportunities from 12/01/23 to 12/31/23. Review of Resident #2's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was an electronic entry for atorvastatin 40mg once daily scheduled at 8:00am. -Atorvastatin 40mg was documented as administered 16 of 17 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24.	C 330		

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C 330	Continued From page 57 Observation of Resident #2's medication on hand on 01/18/24 at 11:50am revealed: -There were three medication cards with atorvastatin 40mg once daily. -Thirty tablets of atorvastatin 40mg were dispensed on 11/10/23; five tablets were available for administration. -Thirty tablets of atorvastatin 40mg were dispensed on 12/08/23; 30 tablets were available for administration. -Thirty tablets of atorvastatin 40mg were dispensed on 01/12/24; 30 tablets were available for administration. -There was a total of 65 tablets of atorvastatin 40mg available for administering. Interview with Resident #2 on 01/18/24 at 3:10pm revealed: -He was ordered atorvastatin once daily, but he did not know why. -He did not know all his medications; he took the tablets that were in his medication cup. b. Review of Resident #2's current FL2 dated 12/20/23 revealed there was an order for travoprost eye drops (used to treat glaucoma) 0.004 % one drop in both eyes daily. Review of Resident #2's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for travoprost 0.004% one drop in each eye at bedtime scheduled at 8:00pm. -Travoprost 0.004% was documented as administered 30 of 30 opportunities from 11/01/23 to 11/30/23. Review of Resident #2's December 2023 MAR revealed:	C 330			

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C 330	Continued From page 58 -There was an electronic entry for travoprost 0.004% one drop in each eye at bedtime scheduled at 8:00pm. -Travoprost 0.004% was documented as administered 31 of 31 opportunities from 12/01/23 to 12/31/23. Review of Resident #2's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was an electronic entry for travoprost 0.004% one drop in each eye at bedtime scheduled at 8:00pm. -Travoprost 0.004% was documented as administered 16 of 17 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. Observation of Resident #2's medication on hand on 01/18/24 at 11:50am revealed: -There were six bottles of travoprost 0.004% one drop in both eyes daily in boxes. -There was a sealed bottle of travoprost 0.004% dispensed on 06/08/23 available for administration. -There was a sealed bottle of travoprost 0.004% dispensed on 10/12/23 available for administration. -There was a sealed bottle of travoprost 0.004% dispensed on 12/15/23 available for administration. -There were two sealed bottles of travoprost 0.004% dispensed on 01/06/24 available for administration. -There was half a bottle of travoprost 0.004% dispensed on 01/13/24 available for administration. -There was a total of five and a half bottles of travoprost 0.004% available for administration. Interview with Resident #2 on 01/18/24 at 3:10pm	C 330		

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C 330	Continued From page 59 revealed: -He had an order for travoprost once daily. -The Supervisor-in-Charge administered his eye drops at dinner time. -He thought the travoprost was for glaucoma. -He had glaucoma surgery a couple of years ago. -The only issue he had with his eyes were sometimes they were itchy. c. Review of Resident #2's current FL2 dated 12/20/23 revealed there was an order for Novolog (used to treat type 2 diabetes) 20 units inject twice daily. Review of Resident #2's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for Novolog 20 units before breakfast and dinner and 15 units before lunch scheduled at 7:30am, 11:30am and 4:30pm. -Novolog 20 units was documented as administered 60 of 60 opportunities from 11/01/23 to 11/30/23. -Novolog 15 units was documented as administered 30 of 30 opportunities from 11/01/23 to 11/30/23. Review of Resident #2's December 2023 MAR revealed: -There was an electronic entry for Novolog 20 units before breakfast and dinner and 15 units before lunch scheduled at 7:30am, 11:30am and 4:30am. -Novolog 20 units were documented as administered 62 of 62 opportunities from 12/01/23 to 12/31/23. -Novolog 15 units were documented as administered 31 of 31 opportunities from 12/01/23 to 12/31/23.	C 330			

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C 330	Continued From page 60 Review of Resident #2's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was an electronic entry for Novolog 20 units before breakfast and dinner and 15 units before lunch scheduled at 7:30am, 11:30am and 4:30am. -Novolog 20 units were documented as administered 28 of 34 opportunities from 01/01/24 to 01/17/24. -Novolog 15 units were documented as administered 14 of 17 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. -The entry for 01/07/24 and 01/08/24 was blank and nothing documented on the acceptations on the MAR. Review of Resident #2's finger stick blood sugar (FSBS) log for November 2023 revealed: -There were FSBS result documented daily at morning and noon; no times were documented. -The same FSBS results for morning were documented for noon. -Resident #2's FSBS ranged from 107 to 155 for the morning and 107 to 155 for noon. Review of Resident #2's finger stick blood sugar (FSBS) log for December 2023 revealed: -There were FSBS result documented daily at morning and noon; no times were documented. -The same FSBS results for morning were documented for the noon results. -Resident #2's FSBS ranged from 112 to 157 for the morning and 112 to 157 for noon. Review of Resident #2's finger stick blood sugar (FSBS) log for 01/01/24 to 01/17/25 revealed: -There were FSBS result documented daily at morning and noon; no times were documented. -The same FSBS results for morning were	C 330			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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C 330	Continued From page 61 documented for the noon results. -Resident #2's FSBS ranged from 104 to 151 for the morning and 104 to 151 for noon. -There were no FSBS results documented on 01/07/24 and 01/08/24. Observation of Resident #2's medication on hand on 01/18/24 at 11:50am revealed: -There were two boxes of Novolog 20 units before breakfast and dinner and 15 units before lunch. -There was an unopened box with five 3 mL pens of Novolog with a dispense date of 01/22/24; five pens were available for administration. -There was an opened box with four 3ml pens of Novolog dispensed on 12/29/23; four pens were available for administration. Interview with Resident #2 on 01/17/24 at 1:43pm revealed: -He was out of pen needles on 01/07/24 and 01/08/24 so his NovoLog could not be administered. -He and the Supervisor-in-Charge (SIC) decided not to do FSBS checks on 01/07/24 and 01/08/24. -He knew how to dial his Novolog pen to 20 units and to 15 units. -He administered his own Novolog three times a day; 20 units before breakfast and dinner and 15 units before lunch time. d. Review of Resident #2's current FL2 dated 12/20/23 revealed there was an order for metformin (used to treat type 2 diabetes) 500mg once daily. Review of Resident #2's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for metformin	C 330		

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C 330	Continued From page 62 500mg twice daily. -Metformin 500mg was documented as administered twice daily 60 of 60 opportunities from 11/01/23 to 11/30/23. Review of Resident #2's December 2023 MAR revealed: -There was an electronic entry for metformin 500mg twice daily. -Metformin 500mg was documented as administered twice daily 62 of 62 opportunities from 12/01/23 to 12/31/23. Review of Resident #1's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was an electronic entry for metformin 500mg twice daily. -Metformin 500mg was documented as administered twice daily 16 of 17 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. Observation of Resident #2's medication on hand on 01/18/24 at 11:50am revealed: -There was a medication card with metformin 500mg one tablet with meals twice daily. -Sixty tablets of metformin 500mg were dispensed on 01/13/24; 52 tablets were available for administration. Interview with Resident #2 on 01/18/24 at 3:10pm revealed: -He had an order for metformin two times a day for his diabetes. -He could not identify his medications. -He took the tablets the SIC gave him in his medication cup twice a day. e. Review of Resident #2's current FL2 dated 12/20/23 revealed there was an order for	C 330		

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C 330	Continued From page 63 olanzapine (used to treat schizophrenia) 5mg once daily. Review of Resident #2's November 2023, December 2023 and January 2024 from 01/01/24 to 01/17/24 medication administration record (MAR) revealed there was not an entry for olanzapine 5mg once daily. Observation of Resident #2's medication on hand on 01/18/24 at 11:50am revealed there was no olanzapine 5mg once daily available for administration. Interview with Resident #2 on 01/18/24 at 3:10pm revealed: -He had a current order for olanzapine, but he did not know why it was ordered. -He could not identify his medications. -He took the tablets the SIC gave him in his medication cup twice a day. f. Review of Resident #2's current FL2 dated 12/20/23 revealed there was not an order for amlodipine (used to treat high blood pressure) 10mg once daily. Review of Resident #2's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for amlodipine 10mg once daily scheduled at 8:00am. -Amlodipine 10mg was documented as administered 30 of 30 opportunities from 11/01/23 to 11/30/23. Review of Resident #2's December 2023 MAR revealed: -There was an electronic entry for amlodipine 10mg once daily scheduled at 8:00am. -Amlodipine 10mg was documented as	C 330			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
NAME OF PROVIDER OR SUPPLIER RISING HOPE HEALTH CARE SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 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 64 administered 31 of 31 opportunities from 12/01/23 to 12/31/23. Review of Resident #2's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was an electronic entry for amlodipine 10mg once daily scheduled at 8:00am. -Amlodipine 10mg was documented as administered 16 of 17 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. Observation of Resident #2's medication on hand on 01/18/24 at 11:50am revealed: -There were two medication cards with amlodipine 10mg once daily. -Thirty tablets of amlodipine 10mg were dispensed on 12/08/23; zero tablets were available for administration. -Thirty tablets of amlodipine 10mg were dispensed on 01/08/24; 30 tablets were available for administration. Interview with Resident #2 on 01/18/24 at 3:10pm revealed: -He was not sure why he had an order for amlodipine, but he thought he took it once a day. -He could not identify his medications. -He took the tablets the SIC gave him in his medication cup twice a day. -His blood pressure was not checked at the facility; his primary care provider (PCP) usually checked his blood pressure at his appointments. -He did not recall any of his blood pressure results. g. Review of Resident #2's current FL2 dated 12/20/23 revealed there was not an order for benzotropine (used to treat Parkinson's disease) 0.5mg at bedtime.	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/18/2024
NAME OF PROVIDER OR SUPPLIER RISING HOPE HEALTH CARE SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 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 65 Review of Resident #2's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for benzotropine 0.5mg at bedtime scheduled at 8:00pm. -Benzotropine 0.5mg was documented as administered 30 of 30 opportunities from 11/01/23 to 11/30/23. Review of Resident #2's December 2023 MAR revealed: -There was an electronic entry for benzotropine 0.5mg at bedtime scheduled at 8:00pm. -Benzotropine 0.5mg was documented as administered 31 of 31 opportunities from 12/01/23 to 12/31/23. Review of Resident #2's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was an electronic entry for benzotropine 0.5mg at bedtime scheduled at 8:00pm. -Benzotropine 0.5mg was documented as administered 16 of 17 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. Observation of Resident #2's medication on hand on 01/18/24 at 11:50am revealed: -There was a medication card with benzotropine 0.5mg one tablet at bedtime. -Thirty tablets of benzotropine 0.5mg were dispensed on 01/08/24; 25 tablets were available for administration. Interview with Resident #2 on 01/18/24 at 3:10pm revealed he was ordered benzotropine one a day about a year ago for leg movement. h. Review of Resident #2's current FL2 dated 12/20/23 revealed there was not an order for	C 330			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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NAME OF PROVIDER OR SUPPLIER RISING HOPE HEALTH CARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 233 GHOLSON AVENUE HENDERSON, NC 27536
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 66 Dorzolamide (used to treat increased pressure in the eye) one drop in each eye twice daily. Review of Resident #2's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for Dorzolamide instill one drop into each eye twice daily scheduled at 8:00am and 8:00pm. -Dorzolamide was documented as administered 60 of 60 opportunities from 11/01/23 to 11/30/23. Review of Resident #2's December 2023 MAR revealed: -There was an electronic entry for Dorzolamide instill one drop into each eye twice daily scheduled at 8:00am and 8:00pm. -Dorzolamide was documented as administered 62 of 62 opportunities from 12/01/23 to 12/31/23. Review of Resident #2's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was an electronic entry for Dorzolamide instill one drop into each eye twice daily scheduled at 8:00am and 8:00pm. -Dorzolamide was documented as administered 32 of 34 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. Observation of Resident #2's medication on hand on 01/18/24 at 11:50am revealed: -There were four 10ml bottles of Dorzolamide one drop both eyes twice daily. -There was a sealed bottle of Dorzolamide dispensed on 07/12/23; a full bottle was available for administration. -There was a sealed bottle of Dorzolamide dispensed on 9/12/23; a full bottle was available for administration. -There was a sealed bottle of Dorzolamide dispensed on 11/15/23; a full bottle was available	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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C 330	Continued From page 67 for administration. -There was an opened bottle of Dorzolamide dispensed on 12/15/23; 1/4 bottle was available for administration. Interview with Resident #2 on 01/18/24 at 3:10pm revealed: -He had an order for Dorzolamide eye drops in both eyes twice a day; they were administered at dinner time. -He thought the Dorzolamide was for glaucoma. -He had glaucoma surgery a couple of years ago. -The only issue he had with his eyes were sometimes they were itchy. -He got his eye drops every night. Attempted telephone interview with the facility's contracted pharmacy on 01/18/24 at 4:27pm was unsuccessful. Attempted telephone interviews with Resident #2's primary care provider (PCP) on 01/18/24 at 12:38pm and 2:33pm were unsuccessful. Attempted telephone interviews with the Administrator on 01/17/23 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. Refer to interview with the Supervisor-in-Charge (SIC) on 01/17/24 at 3:14pm. Refer to interviews with the SIC on 01/18/24 at 10:26am and 1:23pm. 3. Review of Resident #3's current FL2 dated 10/24/23 revealed diagnoses included hypertension, hyperlipidemia, schizophrenia and hypothyroidism. a. Review of Resident #3's current FL2 dated	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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C 330	Continued From page 68 10/24/23 revealed there was an order for latanoprost (used to treat glaucoma) 0.005% one drop in each eye twice daily. Review of Resident #3's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for latanoprost 0.005% instill one drop into each eye at bedtime scheduled at 8:00pm. -Latanoprost was documented as administered 30 of 30 opportunities from 11/01/23 to 11/30/23. Review of Resident #3's December 2023 MAR revealed: -There was an electronic entry for latanoprost 0.005% instill one drop into each eye at bedtime scheduled at 8:00pm. -Latanoprost was documented as administered 31 of 31 opportunities from 12/01/23 to 12/31/23. Review of Resident #3's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was an electronic entry for latanoprost 0.005% instill one drop into each eye at bedtime scheduled at 8:00pm. -Latanoprost was documented as administered 16 of 17 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. Observation of Resident #3's medication on hand on 01/18/24 at 1:08pm revealed: -There were seven bottles of latanoprost 0.005% instill one drop in each eye at bedtime. -There was a sealed bottle of latanoprost dispensed on 09/12/23. -There was a sealed bottle of latanoprost dispensed on 10/11/23. -There was a sealed bottle of latanoprost dispensed on 10/26/23. -There were two sealed bottles of latanoprost	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/18/2024
NAME OF PROVIDER OR SUPPLIER RISING HOPE HEALTH CARE SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 233 GHOLSON AVENUE HENDERSON, NC 27536			
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C 330	Continued From page 69 dispensed on 11/13/23. -There was a sealed bottle of latanoprost with the label removed and there was no dispense date. -There was an opened box of latanoprost dispensed on 11/14/23; there was not an opened date and 1/4 of the bottle was available for administration. -There were six and ¼ bottles of lantanoprost available for administration. Interview with Resident #3 on 01/18/24 at 1:55pm revealed: -He was administered eye drops in both eyes once a day. -The eye drops were for his glaucoma. -He had not had any discomfort or pain; his eyes were okay. b. Review of Resident #3's current FL2 dated 10/24/23 revealed there was an order for amlodipine (used to treat high blood pressure) 10mg once daily. Review of Resident #3's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for amlodipine 10mg once daily scheduled at 8:00am. -Amlodipine 10mg was documented as administered 30 of 30 opportunities from 11/01/23 to 11/30/23. Review of Resident #3's December 2023 MAR revealed: -There was an electronic entry for amlodipine 10mg once daily scheduled at 8:00am. -Amlodipine 10mg was documented as administered 31 of 31 opportunities from 12/01/23 to 12/31/23. Review of Resident #3's January 2024 MAR from	C 330			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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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 70 01/01/24/ to 01/17/24 revealed: -There was an electronic entry for amlodipine 10mg once daily scheduled at 8:00am. -Amlodipine 10mg was documented as administered 16 of 17 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. Observation of Resident #3's medication on hand on 01/18/24 at 1:08pm revealed: -There were five medication cards with amlodipine 10mg administer once daily. -Thirty tablets of amlodipine 10mg were dispensed on 09/08/23; 30 tablets were available for administration. -Thirty tablets of amlodipine 10mg were dispensed on 10/08/23; 30 tablets were available for administration. -Thirty tablets of amlodipine 10mg were dispensed on 11/15/23; 30 tablets were available for administration. -Thirty tablets of amlodipine 10mg were dispensed on 12/15/23; 30 tablets were available for administration. -Thirty tablets of amlodipine 10mg were dispensed on 01/08/24; 30 tablets were available for administration. -There were a total of 150 amlodipine 10mg tablets available for administration for Resident #3. Interview with Resident #3 on 01/18/24 at 1:55pm revealed; -He did not know why he was ordered amlodipine and he could not say if he got it every day. -His blood pressure was not checked by the staff at the facility. c. Review of Resident #3's current FL2 dated 10/24/23 revealed there was an order for	C 330		

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C 330	Continued From page 71 Depakote (used to treat mood disorders) 500mg twice daily. Review of Resident #3's November 2023 medication administration record (MAR) revealed: -There was an electronic entry for Depakote 500mg twice daily scheduled at 8:00am and 6:00pm. -Depakote was documented as administered 60 of 60 opportunities from 11/01/23 to 11/30/23. Review of Resident #3's December 2023 MAR revealed: -There was an electronic entry for Depakote 500mg twice daily scheduled at 8:00am and 6:00pm. -Depakote was documented as administered 62 of 62 opportunities from 12/01/23 to 12/31/23. Review of Resident #3's January 2024 MAR from 01/01/24/ to 01/17/24 revealed: -There was an electronic entry for Depakote 500mg twice daily scheduled at 8:00am and 6:00pm. -Depakote was documented as administered 32 of 33 opportunities from 01/01/24 to 01/17/24; there was nothing documented for 01/17/24. Observation of Resident #3's medication on hand on 01/18/24 at 1:08pm revealed: -There were four medication cards of Depakote 500mg administer twice daily for Resident #3. - in each medication card. -Thirty tablets of Depakote 500mg were dispensed on 12/08/23 on a card labeled 1 of 2; 5 tablets were available for administration. - Thirty tablets of Depakote 500mg were dispensed on 12/08/23 on a card labeled 2 of 2; 30 tablets were available for administration. - Thirty tablets of Depakote 500mg were	C 330			

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C 330	Continued From page 72 dispensed on 01/13/24 on a card labeled 1 of 2; 30 tablets were available for administration. - Thirty tablets of Depakote 500mg were dispensed on 01/13/24 on a card labeled 2 of 2; 30 tablets were available for administration. -There was a total of 95 tablets of Depakote 500mg available for administration. Interview with Resident #3 on 01/18/24 at 1:55pm revealed: -He knew he had an order for Depakote twice a day. -He knew it was a pink tablet. -His primary care provider (PCP) ordered the Depakote and monitored him with lab work. Attempted telephone interview with the facility's contracted pharmacy on 01/18/24 at 4:27pm was unsuccessful. Attempted telephone interviews with Resident #3's primary care provider (PCP) on 01/18/24 at 12:38pm and 2:33pm were unsuccessful. Attempted telephone interviews with the Administrator on 01/17/23 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. Refer to interview with the supervisor-in-charge (SIC) on 01/17/24 at 3:14pm. Refer to interviews with the SIC on 01/18/24 at 10:26am and 1:23pm. Interview with the SIC on 01/17/24 at 3:14pm revealed: -The FL2s were sent with the residents to take to their PCP appointments. -The Administrator sent the completed and signed FL2s to the pharmacy.	C 330			

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C 330	Continued From page 73 -He was not sure who filled out the FL2s. Interviews with the SIC on 01/18/24 at 10:26am and 1:23pm revealed: -Medications in cards were on cycle fill and came every month. -Medications in bottles were not on cycle fill and refills had to be requested from the pharmacy. -Some of the residents had extra medications because a cycle fill order had just been dispensed by the pharmacy a couple of days ago. -The most recently dispensed medication would go into use after the cards being currently used were empty. -He did not know there were medications from June 2023, August 2023, October 2023 and November 2023 still available for administration. -He thought maybe someone had mixed the dates up and not administered the old ones first. -The residents did not refuse to take their medications. -None of the residents had been in the hospital in the last 90 days. -He was out sick for three months in the summer and someone else administered the medications. -He administered the medications with the oldest dispense date first. -He did not know he could request to stop a delivery from the pharmacy. -The residents gave him any documents or paper work when they returned from their physicians' appointment. -He gave all documents and paper work to the Administrator. -The Administrator notified the pharmacy of any new medication orders or changes. -The pharmacy put the medication orders on the MARs. -He pulled the residents' medication the time of the day they were to be administered and placed	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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C 330	Continued From page 74 them into cups. -He did not reference the MAR because he looked at the medication labels. -He made sure the residents were administered all their medication; including eye drops and injections. The facility failed to ensure medications were administered as ordered to 3 of 3 sampled residents including a resident who had medications ordered for hypertension, leg ulcers, hyperlipidemia, and low potassium, and who did not have a current order for a diabetic medication and a medication for high cholesterol (#1) and a resident who was not administered eye drops or medication for high cholesterol, who was not administered two diabetic medications and an antipsychotic medication per physician orders and did not have orders for eye drops, a high blood pressure medication, and an anti-tremor medication (#2) and a resident who who was not administered an eye drop, an anticonvulsant and a high blood pressure medication per physician orders (#3). The facility's failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 01/18/24. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2024.	C 330		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration	C 341		

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C 341	Continued From page 75 (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the documentation on the medication administration records (MARs) for 3 of 3 sampled residents (#1, #2, #3) included the initials of the Supervisor-in-Charge (SIC) and observations of the residents taking their medication. The findings are: Observation of the lunch meal on 01/17/24 at 11:45am revealed: -The SIC removed two of the residents' medications from the medication cards and placed them into clear reusable plastic cups and placed them at each resident's place setting. -The cups did not have any labels or writing on them to indicate which resident's medication was in the cup. -Three residents sat at the table for the lunch meal. -One resident did not come to the dining room and did not eat his lunch meal; his medication was unattended in an open cup on the table. -The SIC was in the kitchen when one of the residents took his medications with his meal; the SIC did not document the administration on the	C 341	Training and education shall be completed with SIC about pre-charting and why it's not prohibited. Ensure that medication is given to the resident directly and making sure that resident takes the medication in the presence of the SIC. This training shall be completed by administrator.	2/13/24

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RISING HOPE HEALTH CARE SERVICES

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HENDERSON, NC 27536**

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C 341	Continued From page 76 Medication administration record (MAR). -The SIC left the dining room and kitchen area and went to his room after the residents finished their meals; one cup with medications remained on the table unattended. -At 12:08pm a resident walked into the dining room and swallowed his medication; the SIC was not in the room. Observation of the dinner meal on 01/17/24 from 4:41pm to 5:00pm revealed: -The SIC had removed the residents' medication tablets from the medication cards and placed them into clear reusable cups. -The cups with the medications in them were placed on the table at the residents' place settings. -The residents came into the dining room and began to sit at the table. -Some of the residents ate their meal. -The residents swallowed their medications from the cups at various times. -The SIC moved in and out of the dining room into the adjacent kitchen during the meal time. 1. Review of Resident #1's current FL2 dated 10/24/23 revealed diagnoses included hypertension, hyperlipidemia, chronic leg ulcer and atrial fibrillation. Review of Resident #1's January 2024 MAR from on 01/18/24 at 10:20am revealed there was no documentation of administration for Resident #1's medications on 01/17/24 and 01/18/24. Observation of the lunch meal on 01/17/24 at 11:45am revealed: -Resident #1 did not come to the table to eat; his medications sat on the table in the open container.	C 341		

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NAME OF PROVIDER OR SUPPLIER RISING HOPE HEALTH CARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 341	Continued From page 77 -The SIC was in the kitchen when one of the residents took his medications with his meal; the SIC did not document the administration on the Medication administration record (MAR). -The SIC left the dining room and kitchen area and went to his room after the residents finished their meals and left Resident #1's medications on the table unattended. -At 12:08pm Resident #1 walked into the dining room and swallowed his medication; the SIC was not in the room. Interview with Resident #1 on 01/18/24 at 12:54pm revealed: -His medications were always in a cup on the table when he came to eat his meals. -He did not always eat lunch so the SIC would leave the medication in the cup on the table. -He would take his medication when he came into the dining room; the SIC would remind him to take them if he forgot at lunch time. Interview with the SIC on 01/17/24 at 11:49am revealed: -He put the medication in cups on the table for all meals each resident had their own cup. -Resident #1 did not usually eat lunch so he left the resident's medication on the table so he could come take them when he was ready. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. Refer to interview with the SIC on 01/18/24 at 1:37pm. 2. Review of Resident #2's current FL2 dated 12/20/23 revealed diagnoses included hypertension, hyperlipidemia, schizophrenia and	C 341			

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C 341	Continued From page 78 type two diabetes. Review of Resident #2's January 2024 MAR from on 01/18/24 at 11:50am revealed there was no documentation of administration for Resident #2's medications on 01/17/24 and 01/18/24. Interview with Resident #2 on 01/17/23 at 12:30 PM revealed: -His medications were always at his place setting at the table for his meals in a plastic cup. -The SIC went back to his room once the residents started eating their meals and did not always stay while they took their medications. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. Refer to interview with the SIC on 01/18/24 at 1:37pm. 3. Review of Resident #3's current FL2 dated 10/24/23 revealed diagnoses included hypertension, hyperlipidemia, schizophrenia and hypothyroidism. Review of Resident #3's January 2024 MAR on 01/18/24 at 1:08pm revealed there was no documentation of administration for Resident #3's medications on 01/17/24 and 01/18/24. Attempted telephone interviews with the Administrator on 01/17/23 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. Refer to interview with the SIC on 01/18/24 at 1:37pm. Interview with the SIC on 01/18/24 at 1:37pm	C 341		

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C 341	Continued From page 79 revealed: -He pre-poured the residents' medications into the plastic cups and placed them on the table because it was easier to administer to the residents. -He pulled one resident's medication at a time and placed them into the medication cups. -The residents sat at the same place at the table for each meal. -He stayed in the room and the residents took their medication at almost the same time. -He provided water at every meal, so he knew the residents swallowed their medication; he did not need to check. -He documented medication administration at the end of the day on the MAR because he knew what he had administered to the residents. -He did not know he was supposed to document on the MAR after administering medication to each resident; he thought it was okay to do at the end of the day. -He did not know he could not place medication cups on the table for the residents to take. -He did not know he had to administer medication one resident at a time and document after that administration. -The Administrator had seen the medication cups on the table at meal times.	C 341			
C 350	10A NCAC 13G .1005 (a and b) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a	C 350	Administrator and SIC Shall make sure any residents giving themselves any medication has an Self admin order signed		

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C 350	Continued From page 80 physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) The facility shall notify the physician when: (1) there is a change in the resident's mental or physical ability to self-administer; (2) the resident is non-compliant with the physician's orders; or (3) the resident is non-compliant with the facility's medication policies and procedures. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a physician's order to self-administer medication for 1 of 1 sampled residents (#2) who self-administered medications used to control blood sugar by injection. The findings are: Review of Resident #2's current FL2 dated 12/20/23 revealed: -Diagnoses included hypertension, hyperlipidemia, schizophrenia and type two diabetes. -There was an order for Novolog (used to treat type 2 diabetes) 20 units inject twice daily. Observation of Resident #2 on 01/17/24 at 4:41pm revealed:	C 350	By physician and a self admin assessment is completed.	

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C 350	Continued From page 81 -He retrieved his Novolog pen from the refrigerator himself and sat on a stool. -He dialed his Novolog pen to 20 units and administered it to himself by inserting the pen in his abdomen. Observation of Resident #2 on 01/18/24 at 8:33am revealed he opened the unlocked refrigerator and took his Novolog insulin pen with him to his day program. Review of Resident #2's most current care plan revealed: -The box on the top right-hand corner of the care plan was not filled out and was not dated. -The Administrator had signed and dated the care plan on 06/01/23. -Resident #2 was totally dependent on all tasks with eating, toileting, ambulation, bathing, dressing, grooming and transferring. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluations revealed: -The most current LHPS evaluation was dated 10/12/22. -Tasks included medication administration through injection. -Staff had been trained on insulin injections. -There were no other LHPS evaluations in Resident #2's record. Review of Resident #2's record revealed: -There was a document dated 01/22/15 for Resident #2 to self-administering Novolog 25 units with lunch under supervision; the order was not signed. -There was no evaluation for self-administering Novolog for Resident #2. -There were no other signed physicians' orders	C 350			

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C 350	Continued From page 82 for Resident #2 to self-administer Novolog by injection. Review of Resident #2's November 2023, December 2023, and January 2024 from 01/01/24 to 01/17/24 medication administration record (MAR) revealed: -There was an electronic entry for Novolog 20 units before breakfast and dinner and 15 units before lunch scheduled at 7:30am, 11:30am and 4:30pm. -Novolog 20 units was documented as administered 60 of 60 opportunities from 11/01/23 to 11/30/23. -Novolog 15 units was documented as administered 30 of 30 opportunities from 11/01/23 to 11/30/23. -Novolog 20 units were documented as administered 62 of 62 opportunities from 12/01/23 to 12/31/23. -Novolog 15 units were documented as administered 31 of 31 opportunities from 12/01/23 to 12/31/23. -Novolog 20 units were documented as administered 28 of 34 opportunities from 01/01/24 to 01/17/24. -Novolog 15 units were documented as administered 14 of 17 opportunities from 01/01/24 to 01/17/24. Interview with Resident #2 on 01/17/24 at 1:43pm revealed: -He knew how to dial his Novolog pen to 20 units and to 15 units. -He administered his own Novolog three times a day; 20 units before breakfast and dinner and 15 units before lunch time. -He attended a day program and took a Novolog pen with him to his day program so he could administer his Novolog while at the program.	C 350			

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C 350	Continued From page 83 -There was no one at the day program to administer his medication for him. -He had always administered his own Novolog. -He thought his primary care provider (PCP) had written a note for him to administer his on Novolog but it had been a long time ago. Interview with the Supervisor-in-Charge (SIC) on 01/18/24 at 1:23pm revealed: -Resident #2 administered his own insulin injections. -Resident #2 had always administered his own insulin. -He never asked about it because that was the way it was when he started working at the facility. -He did not know if Resident #2 had a self-administer order for his Novolog injection. -Resident #2's Novolog pen was stored in the butter compartment on the door so the resident could get it any time he wanted. Attempted telephone interviews with Resident #1's PCP on 01/18/24 at 12:38pm and 2:33pm were unsuccessful. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful.	C 350			
C 353	10A NCAC 13G .1006 (b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration.	C 353			

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C 353	Continued From page 84 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications for residents were stored in a locked container in the refrigerator. The findings are: Observation of the refrigerator in the kitchen on 01/17/24 at various times between 8:30am to 5:47pm revealed: -At 8:46am, the refrigerator in the kitchen was unlocked; there was a pad lock and a closure on the door, but the pad lock was not locked and hung open. -There was a butter storage compartment on the inside door of the refrigerator with a Novolog (used to treat type two diabetes) injectable pen in a clear plastic resealable bag; the Novolog pen was not labeled. -Inside the refrigerator was a small black box with a built-in dial combination lock; the closure was in the upright position and the box was unlocked. -There were two boxes of Novolog injectable pens and two boxes of Ozempic injectable pens inside the box; each box was labeled with the order and the residents' names. -At 12:08pm, a resident went to the refrigerator and got ice out of the top freezer compartment; the refrigerator and the black storage box were both unlocked. -At 4:41pm, the refrigerator was unlocked and a resident went into it and retrieved his Novolog pen from the butter storage compartment of the door. -At 5:47pm, the refrigerator was unlocked; the padlock was on the refrigerator, but it was not snapped closed. Observation of the refrigerator in the kitchen on	C 353	Administrator and SIC 2/7/04 Shall ensure medication is stored and locked properly at all times. They both shall ensure that all medication is labeled properly.		

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C 353	Continued From page 85 01/18/24 at various times between 8:30am to 3:32pm revealed: -At 8:33am, a resident opened the unlocked refrigerator and removed his insulin pen from the butter storage compartment on the door; the black storage box was also unlocked. -At 9:10am, there were residents in the room adjacent to the kitchen and the refrigerator and the black storage box inside the refrigerator were not locked; the Supervisor-in-Charge (SIC) was in his room with the door closed. -At 10:19am, a resident went to the refrigerator and got ice out of the top freezer compartment; the refrigerator and the black storage box were both unlocked. -At 3:11pm, a resident returned from his day program and placed his Novolog pen back into the butter storage compartment on the inside door of the refrigerator. -At 3:23pm, the refrigerator in the kitchen and the black storage box stored inside the refrigerator were not locked. Interview with a resident on 01/17/24 at 12:08pm revealed: -He went into the freezer part of the refrigerator to get ice. -He never went into the refrigerator for anything. -He thought the refrigerator was locked because he saw the pad lock hanging on it. -He knew his Ozempic pens were stored in the black storage box in the refrigerator, but he did not know if it was locked. -The SIC always got the Ozempic pens out of the black storage box and administered them. Interview with another resident on 01/18/24 at 3:23pm revealed: -He administered his own Novolog. -He attended a day program and took his	C 353			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/18/2024
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NAME OF PROVIDER OR SUPPLIER RISING HOPE HEALTH CARE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 233 GHOLSON AVENUE HENDERSON, NC 27536
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C 353	Continued From page 86 Novolog with him to his day program. -His Novolog was stored in the refrigerator. -The refrigerator was left unlocked during the day so he could get in when he needed it. -The current Novolog pen he was using was kept in a plastic baggy in a storage bin on the door. -His unused Novolog pens were stored in the box in the unlocked black storage box in the refrigerator. -He did not go into the black storage box for his Novolog pens; he asked the SIC to get them for him. -The SIC would go to his room up stairs between meals and leave the refrigerator unlocked. -He would go into the refrigerator and get another resident his beverages for the resident when he wanted one. Interview with the SIC on 01/18/24 at 1:23pm revealed: -The refrigerator had a closure and a padlock to keep the residents out. -He did not lock the refrigerator during the day, he flipped over the closure and put the padlock through the hole but did not snap it closed. -He would lock the refrigerator at the end of the day by snapping it closed. -He left it unlocked so the residents could get drinks. -A resident self-administered his Novolog so the Novolog pen was stored in the butter compartment on the door so the resident would get it any time he wanted. -The black storage box with the Novolog and the Ozempic pens was never locked because he did not know the combination. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful.	C 353		

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C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure quarterly pharmaceutical	C 375	Administrator shall hire a licensed pharmacist to conduct quarterly Reviews.	

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RISING HOPE HEALTH CARE SERVICES

233 GHOLSON AVENUE

HENDERSON, NC 27536

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C 375	Continued From page 88 reviews were completed for 3 of 3 sampled residents (#1, #2, and #3). The findings are: 1. Review of Resident #1's current FL2 dated 10/24/23 revealed diagnoses included hypertension, hyperlipidemia, chronic leg ulcer and atrial fibrillation. Review of Resident #1's pharmacy reviews revealed: -There was a completed pharmacy review dated 11/30/23. -The previous pharmacy review was dated 02/09/23. Attempted telephone interview with the facility's contracted pharmacy on 01/18/24 at 4:27pm was unsuccessful. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. Refer to interview with the SIC on 01/17/24 at 3:00pm. 2. Review of Resident #2's current FL2 dated 12/20/23 revealed diagnoses included hypertension, hyperlipidemia, schizophrenia and type two diabetes. Review of Resident #2's pharmacy reviews revealed: -There was a completed pharmacy review dated 11/30/23. -The previous pharmacy review was dated 02/09/23.	C 375		

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C 375	Continued From page 89 Attempted telephone interview with the facility's contracted pharmacy on 01/18/24 at 4:27pm was unsuccessful. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. Refer to interview with the SIC on 01/17/24 at 3:00pm. 3. Review of Resident #3's current FL2 dated 10/24/23 revealed diagnoses included hypertension, hyperlipidemia, schizophrenia and hypothyroidism. Review of Resident #3's resident register revealed an admission date of 07/30/15. Review of Resident #3's pharmacy reviews revealed: -There was a completed pharmacy review dated 11/30/23. -The previous pharmacy review was dated 02/09/23. Attempted telephone interview with the facility's contracted pharmacy on 01/18/24 at 4:27pm was unsuccessful. Attempted telephone interviews with the Administrator on 01/17/24 at 5:51pm and on 01/18/24 at 3:44pm were unsuccessful. Refer to interview with the SIC on 01/17/24 at 3:00pm. Interview with the SIC on 01/17/24 at 3:00pm revealed he did not have anything to do with the pharmacy reviews; the Administrator did them.	C 375			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL091017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/18/2024
NAME OF PROVIDER OR SUPPLIER RISING HOPE HEALTH CARE SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 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	