Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL070011	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF LOVE FAMILY CARE HOME	1904 JOHNSON RD ELIZ CITY, NC 27909

(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 on 02/29/24 to 03/01/24.	C 000	The corrective action that has taken place to correct the deficient area of C246 10A NCAC 13G.902(b) Healthcare is staff training. All staff members has been trained to review appointment sheets that are located in the MAR, the staff communication log, the Resident Chart and on the designated Staff area. Each Staff is to report upcoming appointments to their relief staff. The measures that have been put in place to prevent the deficiency from occuring	3-4-24
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 interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine and mental health needs for 1 of 3 sampled residents (Resident #2) related appointments for therapy and medication management. The findings are: Review of Resident #2's FL2 dated 05/25/23 revealed: -Diagnoses included unspecified cognitive function, unspecified dementia, type 2 diabetes, obesity, and gastroesophageal (GERD). -There was an order for Risperidone 2mg one tablet twice daily to treat anxiety. -Resident #2's orientation was intermittent. Review of Resident #2 record on 12/29/23 at 2:28pm revealed there was no documentation of Resident #2's mental health services. Telephone interview with Resident #2's mental health provider on 03/01/24 at 9:41am revealed: -Resident #2 was to be seen every 90 days for therapy and medication management. -Resident #2 was last seen on 10/04/23 for medication management.	C 246		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X5) DATE

Angela Hardy — administrator — 3-12-2024

STATE FORM 6899 N18Q11 If continuation sheet 1 of 5

Reviewed & Acknowledged
Angela Y. Hardy 04/05/24

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C 246	Continued From page 1 -Resident #2 was a no show/no call for her yearly assessment on 06/19/23. -Resident #2 was a no show/no call for her medication management on 01/03/24. Telephone interview with Resident #2's family member on 03/01/24 at 12:24pm revealed: -Resident #2 received mental health services from a local provider. -She was not sure when Resident #2 had last seen her mental health provider because the facility staff takes Resident #2 to her appointments. -She had not been informed of Resident #2 missing her mental health appointments. Interview with the Administrator on 03/01/24 at 10:08am revealed: -Resident #2 received mental health services from a local mental health provider. -She was last seen in November 2023. -She had not documented the mental health services in Resident #2 record. -She had not requested a copy of Resident #2's evaluation or visit summaries. -She or the Assistant Administrator scheduled residents appointments and documented the appointments in the staff communication log. -She was not aware of Resident #2 missing the 06/19/23 appointment. -Resident #2 did not have any upcoming appointments with her mental health provider. Based on observations, record reviews, and interviews, it was determined that Resident #2 was not interviewable.	C 246	again is staff training and appointment slips. The provider has also been informed with an alternative phone number for appointment reminders and confirmation. The administrator or the administrative assistant will monitor the situation on a daily basis to ensure this will not happen again. This plan of correction was completed on March 4, 2024.	
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care	C 249		

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C 249	Continued From page 2 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 3 sampled residents (#1) with orders for blood pressure checks once weekly. The findings are: Review of Resident #1's current FL2 dated 12/07/23 revealed: -Diagnoses included acute kidney injury, hypertension disorder, cerebrovascular accident, malignant tumor of cervix, hyperlipidemia, metabolic encephalopathy, and subacute non-traumatic intracranial subdural hemorrhage. -There was an order to complete blood pressure (BP) checks weekly. Review of Resident #1's Resident Register dated 12/07/23 revealed Resident #1 was admitted to the home on 12/07/23. Review of Resident #1's Licensed Health Professional Support (LHPS) dated 12/27/23 revealed there were no LHPS tasks. Review of Resident #1's Medication Administration Record (MAR) for December 2023	C 249	The corrective action that has been put in place to correct the deficient area of C249 NCAC 13.G.0902 Healthcare (c),(3) and(4). IS Staff training. All staff members that are Responsible for taking vital signs must Record the measurment on the vital sheet that has been placed in the Resident Chart as well as in the MAR En which the task has been added.	3-4-2024

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C 249	Continued From page 3 revealed there was not an entry for weekly BP checks. Review of Resident #1's MAR for January 2024 revealed there was not an entry for weekly BP checks. Review of Resident #1's MAR for February 2024 revealed there was not an entry for weekly BP checks. Interview with Resident #1 on 02/29/24 at 12:57pm revealed: -She had high blood pressure. -She took medication to treat the high blood pressure. -She did not know how often she was to have her BP checked but it was last checked about two or three weeks ago. Telephone interview with Resident #1's Primary Care Physician's Nurse on 03/01/24 at 9:07am revealed: -Resident #1 was last seen on 12/27/23 for a follow up. -Resident #1 was to get her BP checked once weekly. Interview with the Administrator on 02/29/24 at 2:38pm revealed: -She misread the order for weekly BP checks for Resident #1 and thought the BP checks were as needed. -Resident #1's last BP check was on 01/20/24 at 114/81. -Resident #1's BP checks were documented in the staff communication log and not on her MAR. -The Administrator did not provide a copy of the 01/20/24 staff communication log. -Resident #1 had not complained or shown any	C 249	The measures that have been put in place is Staff training, a vital sheet in the resident chart as well as the task being added to the MAR. Licensed Health Professional Support has also been informed to add task, the administrator and/or administrative asst will monitor the situation to ensure that this deficiency do not happen again	

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C 249	Continued From page 4 symptoms of high blood pressure.	C 249	This plan of correction was completed on March 4, 2024	