

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL019023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/26/2024
NAME OF PROVIDER OR SUPPLIER CHATHAM RIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey and a state involved complaint investigation September 24, 2024 through September 26, 2024.	D 000		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure contact with the resident's prescribing practitioner for clarification of medication orders for 1 of 5 sampled residents (#1) who had orders for medications for high blood pressure/angina, behaviors/seizures, dementia, low iron level in blood, and mental health disorder. The findings are: Review of Resident #1's current FL2 dated 02/16/24 revealed diagnoses included atrial fibrillation, hypertension, type 2 diabetes, hyperlipidemia, diastolic heart failure,	D 344	A cart audit was completed on 9/27 by Resident Care Coordinators (RCC) for Assisted Living and Memory Care. Pharmacy conducted MAR/cart/chart audit on 10/9 and 10/10 for accuracy Assited Living and Memory Care. RCC and/or designee will review orders for accuracy and obtain clarificataion with PCP when needed. Director of Clinical Services provided education to Med Techs regarding the med order clarification process as it relates to accuracy of order, resident, and PCP. Training to be completed by 11/1/24.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Administrator

10-11-24

STATE FORM

6899

G68V11

If continuation sheet 1 of 18

Reviewed and acknowledged 10/14/24.

Catherine Prater

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D 344	Continued From page 1 hypothyroidism, chronic depression, and Sjogren's syndrome (immune system disorder causing dry eyes and mouth). Interview with Resident #1's family member on 09/24/24 at 11:00am revealed: -She was Resident #1's Power of Attorney. -She was actively involved in Resident #1's care including managing her doctor visits and her medication. -She visited Resident #1 frequently at the facility. -Resident #1's primary care provider (PCP) was not the facility's contracted PCP. -The facility had experienced recent turnover in the nursing staff and administration. -The family member had verified current medications with Resident #1's current PCP on 07/11/24. -Resident #1 had 5 medications ordered on 07/12/24 by a PCP that was not Resident #1's provider and were administered from 07/12/24 until 07/30/24 that were listed on Resident #1's medication profile received from the facility on 07/15/24. -She had difficulty corresponding with the facility's nursing staff and administration related to the medications not ordered by Resident #1's PCP on 07/11/24 but listed on Resident #1's current medications dated 07/15/24. -Resident #1 seemed to have lost weight from 07/13/24 to 07/31/24 but had not had any hospital visits or seen her PCP. -Resident #1 was discharged from the facility on 07/31/24. Review of the FL2 verification form dated 07/12/24 revealed: -The form was computer generated. -The form had Resident #1's name and date of birth at the top.	D 344		

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D 344	Continued From page 2 -The form contained orders as follows: Amlodipine 5mg (used to treat blood pressure and angina) one daily; divalproex sprinkle 125mg (used to treat behaviors or seizures) 2 capsules twice a day; ferrous sulfate (a vitamin supplement) 325mg at breakfast; risperidone (used to treat mental health disorders) 0.5mg twice a day at 8:00am and 5:00pm; and simvastatin (used to treat elevated cholesterol) 10mg at bedtime. -The form was documented as a verbal order taken by the Nurse at the sister facility with a notation the orders were received verbally from a named PCP contracted at the sister facility (not Resident #1's PCP). "Please sign the above orders and fax to" (name of sister facility where the Nurse routinely worked) with a fax number included was also noted at the bottom of the form. Review of Resident #1's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Amlodipine 5mg one daily scheduled for administration at 8:00am and documented as administered from 07/13/24 to 07/31/24. -There was an entry for divalproex sprinkle 125mg 2 capsules twice a day, scheduled for administration 8:00am and 8:00pm and documented as administered from 07/13/24 to 07/29/24 at 8:00am. -There was an entry for ferrous sulfate 325mg at breakfast scheduled at 8:00am documented as administered from 07/13/24 to 07/31/24. -There was an entry for risperidone 0.5mg twice a day at 8am and 5pm scheduled for administration at 8:00am and 5:00pm from 07/13/24 at 5:00pm to 07/29/24 at 8:00am. -There was an entry for simvastatin 10mg at	D 344		

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D 344	Continued From page 3 bedtime scheduled for administration at 8:00pm and documented as administered at 8:00pm from 07/13/24 to 07/30/24 except refused on 07/29/24. Telephone interview with pharmacist at the contracted pharmacy on 09/26/24 at 11:32am revealed: -The pharmacy medical record staff entered orders for the pharmacy. -Both FL2 verification orders came at the same time on 07/12/24. -There were no drug to drug interactions with the medications entered so the orders were not flagged for pharmacist review related to duplicate therapy or conflict of administration. -The entry staff could have questioned the orders with different dates and different PCPs. -The pharmacy dispensed a quantity sufficient to last to the next cycle fill for all 5 medications. Review of Resident #1's medications signed out for leave of absence revealed the resident received none of the 5 medications ordered by the FL2 verification form dated 07/12/24. Interview with the Special Care Unit Coordinator (SCUC) on 09/26/24 at 10:00am revealed: -She was working on 07/12/24. -The Resident Care Coordinator (RCC) for the assisted living (AL) unit was routinely responsible for medication management for the residents in the AL. -The SCUC was routinely responsible for managing medications for residents in the SCU. -The RCC was out of the facility on 07/12/24, so the SCUC was assisting with processing medication orders for the AL and SCU. -The SCUC had a note attached to a folder requesting medication orders be faxed to the contracted pharmacy.	D 344		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHATHAM RIDGE ASSISTED LIVING

114 POLKS VILLAGE LANE

CHAPEL HILL, NC 27517

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D 344	Continued From page 4 -There was a document labeled FL2 verification form with medication orders with Resident #1's name from a PCP and a second FL2 verification form with medication orders with Resident #1's name from a PCP contracted with a sister facility. -The SCUC was supposed to contact the facility Nurse to clarify any medications if needed, however the facility's Nurse position was vacant due to staff turnover. -A Nurse from a sister facility had been assigned to assist the facility with medication management. -The Nurse from the sister facility and the Interim Manager had met with Resident #1's family member on 07/10/24. -The Interim Administrator and left the note for the SCUC to fax Resident #1's medication orders to the contracted pharmacy. -She did not contact the Nurse from the sister facility for clarification when orders from 2 different PCPs were to be faxed to the contracted pharmacy. -On 07/30/24, Resident #1's family member came to the facility and met with the SCUC. -That was when she was informed by the family member Resident #1 was administered the medications from the FL2 verification form dated 07/12/24 with Resident #1's name but not her PCP or medications. -She did not follow-up with Resident #1's PCP until 07/29/24 when the family member came to the facility. -She emailed the contracted pharmacy representative with the current list of Resident #1's medications dated 07/11/24 from the resident's PCP on 07/29/24 at 5:50pm stating the resident had never seen the PCP on the FL2 verification form dated 07/12/24 and could the pharmacy discontinue the other medications. On 07/30/24, the representative from the contracted pharmacy told her it would be better if	D 344		

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STATE FORM

6889

G68V11

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D 344	Continued From page 5 there was an order to discontinue the 5 medications from the 07/12/24 from a provider. -On 07/31/24, Resident #1's family member requested medications for leave of absence but only took the medications from the resident's PCP matching orders dated 07/11/24 from the PCP. -She had not seen Resident #1 since 07/31/24. Interview with the RCC on 09/26/24 at 10:15am revealed: -She was responsible for managing medications for the resident in the AL unit. -She was out of the facility from 06/26/24 to 07/17/24 and not present on 07/12/24 when Resident #1's orders were faxed to the contracted pharmacy. -She routinely had conversations or emails with Resident #1's family member regarding medications and care. -She did not have correspondence with Resident #1's family member regarding medications after 07/12/24. -She was surprised when Resident #1's family member requested a discharge for the resident on 07/31/24. -Routinely, the RCC reviewed medication orders for the AL residents when new or verified orders were faxed to the contracted pharmacy. -No staff had reported Resident #1 had been observed to have any noticeable changes in her behavior or weight loss. -She had not reviewed Resident #1's medications upon return to the facility on 07/17/24 or before 07/31/24. -She did not know Resident #1 had medications ordered by a second PCP dated 07/12/24. -The RCC had conversations or emails with the family member from 07/17/24 to 07/31/24 because the family member was working with the	D 344			

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D 344	Continued From page 6 SCUC. Interview with the Nurse from a sister facility on 09/26/24 at 12:05pm revealed: -She worked with the former Interim Manager at a sister facility as the facility's Nurse. -She met with the Interim Manager and Resident #1's family member at the resident's facility on 07/11/24 for reviewing medications and overall care of the resident. -The family member had gotten a FL2 verification of medications signed on 07/11/24 before the meeting. -The Nurse was sharing time and fielding calls for both facilities while on site at the meeting. -The Nurse did not know there was a second FL2 verification dated 07/12/24 with Resident #1's name, and medications that were not on Resident #1's FL2 verification dated 07/11/24. -She requested the facility transmit the orders dated 07/12/24 for her review. -The Nurse received the form by inter-office email at 12:10pm. Interview with the Nurse from a sister facility on 09/26/24 at 12:15pm revealed: -She had not seen the FL2 verification form dated 7/12/24 for Resident #1 until today. -She recognized the medications and the date of the orders. -The medications were for a resident residing at the sister facility and were for clarification of orders when that resident (not Resident #1) returned after a hospital stay. -She used a standardized corporate form in her computer to process telephoned medication orders received from providers. -She had seen times in the past when a resident's name populated on the form that had remained from previous FL2 verification form	D 344			

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D 344	Continued From page 7 processing. -When that incorrect name appeared, she had caught the error and corrected it before processing. -She did not remember correcting the form but perhaps the form printed prior to her changing the name to the correct patient. -Apparently, the form got printed incorrectly and placed in Resident #1's folder to be faxed to the contracted pharmacy. -Medications orders were supposed to be reviewed by the RCC and SCUC as a safety check. -Two different FL2 verification orders close to same date and by 2 different PCPs should routinely be a prompt for RCC or SCUC to contact the Nurse for clarification. -If facility staff had notified the Nurse previously, she would have recognized the error and corrected the oversight with the facility and the contracted pharmacy. -With the RCC out and the SCUC assuming duties until the RCC returned, the medications being for the wrong resident must have been overlooked. -Resident #1 had been discharged from the facility at the end of July 2024 or first part of August 2024, but she would do a medication error report for her file. Interview with the former Interim Manager on 09/26/24 at 12:20pm revealed: -The facility had turnover in the Administrator position in June 2024. - She was coming to the facility to assist with administrative duties. -She had several conversations in person and through emails with Resident #1's family member related to medications and care. -The RCC and the SCUC were responsible for	D 344			

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D 344	Continued From page 8 managing medications for residents. -The medication aides (MAs) could fax new orders to the contracted pharmacy if the orders were received when the RCC or SCUC were not in the building. -She and the Nurse from a sister facility met with Resident #1's family member on 07/11/24 at which time the family member gave them the FL2 verification form dated 07/11/24 by the resident's PCP (not a facility contracted PCP). -She had prepared a folder with the FL2 verification medications dated 07/11/24 for the SCUC to fax to the contracted pharmacy in the absence of the RCC. -She notified Resident #1's family member by email on 07/12/24 that the medications were being faxed to the contracted pharmacy and before leaving to be on leave starting 07/12/24. -She was not aware of Resident #1's second physicians orders dated 07/12/24 were in the folder to faxed to the contracted pharmacy. -She did not know why Resident #1 was discharged from the facility on 07/31/24 until she was informed today (09/26/24) that there were medications in addition to the orders dated 07/11/24 added to Resident #1's medications. -She would have checked with the Nurse from the sister facility for clarification since she was in the meeting on 07/11/24 with Resident #'s family member. Interview with two AL personal care aides (PCAs) and a MA who routinely performed personal care, including bathing on 09/26/24 at 1:45pm revealed: -Resident #1 had been gone from the facility more than a month. -Resident #1 received baths in the mornings twice a week. -Resident #1 was not observed with apparent	D 344		

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D 344	Continued From page 9 weight loss such as a loose-fitting incontinent brief with incontinence care. -Resident #1's clothes appeared to fit the same, as best they remembered. Interview with a MA in the AL unit who routinely administered Resident #1's medications on 09/26/24 at 1:48pm revealed: -Resident #1 may have been a little harder to arouse in the mornings. -Resident #1 did not appear to behave or interact with her differently from 07/13/24 to 0731/24. Interview with the Regional Director of Operations on 09/26/24 at 2:00pm revealed: -The clinical staff (MAs, the RCC and or SCUC), and the facility's Nurse should review medication orders for completeness and accuracy. -The Nurse from the sister facility would be the contact for clarification of orders. -He was aware Resident #1's family member was very active in Resident #1's care including medication orders. -He would have expected the family member to have responded to the medications not being correct when she learned of the issue on 07/15/24, instead of waiting until 07/29/24 to speak to the SCUC.	D 344			
D 430	10A NCAC 13F .1106 (d) Settlement Of Cost Of Care 10A NCAC 13F .1106 Settlement Of Cost Of Care (d) When a resident gives notice of leaving the facility, as may be required by the facility according to Rule .0702(i) of this Subchapter, and leaves at the end of the notice period, the facility shall refund the resident the remainder of any	D 430			

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D 430	Continued From page 10 advance payment within 14 days from the date of notice. If notice is not required by the facility, the refund shall be made within 14 days after the resident leaves the facility. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure the remainder of 1 of 3 sampled residents (#2) advance payments were refunded within 14 days of the resident's end of notice of discharge from the facility. The findings are: Review of Resident #2's FL2 dated 06/28/24 revealed diagnoses included vascular dementia and major depressive disorder. Review of Resident #2's Resident Register revealed an admission date of 05/29/24 and a discharge date of 07/03/24. Review of Resident #2's resident and care agreement revealed: - Resident #2's family representative acknowledged and signed the contract on behalf of Resident #2 on 05/15/24. - The agreement referenced the facility's refund policy for issuing a refund within 14 days following the possibility of Resident #2 providing a 14-day written notice of discharge. Review of the facility's written policy on refunds and terminations, dated 10/24/23, revealed:	D 430	Executive Director/designee will be responsible for submitting refunds within 14 days following discharge, when appropriate notice is giving by resident or responsible party. Regional Director of Operations will conduct an audit for each refund for 3 months and a random thereafter for compliance.		

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D 430	Continued From page 11 - Residents would receive a refund of any payments within 14 days of termination of the resident and care agreement. - Residents could terminate the agreement, with or without cause, upon 14 days prior written notice of discharge provided to the facility. Review of Resident #2's 14-Day Written Notice of discharge revealed: - Resident #2's family representative was provided a notice of discharge on 06/28/24. - Resident #2's would be moved from the facility on 07/03/24. - Resident #2's family representative referenced Resident #2's resident and care agreement of a 14-day written notice of discharge by acknowledgement of Resident #2's financially responsible 07/12/24 end date. Review of the facility accounts payable check detail for Resident #2, dated between 07/01/24 through 09/25/24 for Resident #2 revealed: - The final refund of \$11,262.27 was invoiced on 08/06/24 for Resident #2. - The check for the final refund of \$11,262.27 was issued on 08/13/24 for Resident #2. Review of email correspondence between Resident #2's family representative and the facility contacts dated between June 2024 and August 2024 revealed: -On 06/28/24, Resident #2's family member provided a 14-day written notice of discharge which referenced a physical move-out date of 07/03/24 and Resident #2's financially responsible end date of 07/12/24. -On 07/03/24, Resident #2's family representative communicated with the Sales and Marketing Director and the former Business Office Manager (BOM) about moving Resident #2 from the facility	D 430		

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D 430	Continued From page 12 on 07/03/24 with an attachment of the previous 14-day written notice from 06/28/24 with Resident #2's financially responsible end date of 07/12/24. -Additionally, on 07/03/24, Resident #2's family member further communicated with the former interim Manager and the Regional Director of Operations (RDO) about concerns which included clarification for Resident #2's financially responsible end date of 07/12/24 related to Resident #2 moving from the facility on 07/03/24 and an attachment of the previous 14-day written notice of discharge dated 06/28/24. -On 07/09/24, Resident #2's family representative communicated with the BOM, Sales and Marketing Director, the former interim Manager, and the RDO about an update on billing concerns from his 07/03/24 previous communication which requested clarification for Resident #2's financially responsible end date of 07/12/24 within the 14-day notice of discharge. -On 07/09/24, the BOM communicated with Resident #2's family member requesting a physical mailing address to send Resident #2's family member a refund check. -Additionally on 07/09/24, Resident #2's family representative requested invoice copies from the BOM due to billing concerns included on the BOM's 07/09/24 previous email communication to Resident #2's family representative. -Also on 07/09/24, Resident #2's family representative further communicated billing concerns to the BOM, Sales and Marketing Director, former interim Manager, and the RDO which included clarification on Resident #2's financially responsible end date of 07/12/24 and an attachment of the 14-day written notice of discharge from 06/28/24. -On 07/17/24, Resident #2's family representative requested an update from the BOM related to his 07/09/24 communication on billing concerns	D 430		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL019023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/26/2024
NAME OF PROVIDER OR SUPPLIER CHATHAM RIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 430	Continued From page 13 which included clarification on Resident #2's financially responsible end date of 07/12/24. -On 07/22/24, Resident #2's family representative requested a clarification update from the BOM, the Sales and Marketing Director, the former interim Manager, and the RDO for Resident #2's financially responsible end date of 07/12/24 related to his 07/09/24 communication. -Additionally on 07/22/24, Resident #2's family representative communicated a reminder for an update with the BOM on billing questions which included clarification on Resident #2's financially responsible end date of 07/12/24 with the BOM to coincide with the 14-day written notice of discharge dated 06/28/24. -On 07/23/24, the BOM communicated to Resident #2's family representative that the BOM would follow up with Resident #2's family representative before the end of 07/23/24 once she reviewed the ledger and financial information without addressing clarification related to Resident #2's financially responsible end date of 07/12/24. -On 08/06/24, the BOM communicated with Resident #2's family representative to request a "good" physical mailing address for sending the refund to Resident #2's family representative. -Additionally on 08/06/24, the BOM further communicated with Resident #2's family representative to follow up with the BOM if Resident #2's family representative had not received the refund within 1-2 weeks. -On 08/19/24, Resident #2's family representative communicated with the BOM that the refund check arrived in the mail. Interview with the Sales and Marketing Director on 09/26/24 at 10:55am revealed: -She was not aware of the exact date a 14-day written notice of discharge was provided by	D 430		

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D 430	Continued From page 14 Resident #2's family representative but knew Resident #2 was moving out eventually. -She had not been involved in the email communication between Resident #2's family representative and the facility except for telling Resident #2's family representative the former Business BOM was on vacation in an email on 07/03/24. -The former BOM was responsible for ensuring refunds were provided to the resident's or the resident's family representatives when a resident provided a 14-day written notice of discharge. -She was not aware refunds were to be provided to the resident or the resident's family representative within 14 days of a 14-day notice of discharge because she thought refunds were provided within 30 days for all discharges. -She was not aware the former BOM had not provided a refund to Resident #2's family representative within 14 days of Resident #2 being discharged from the facility on 07/12/24. Interview with the RDO on 09/26/24 at 11:45am revealed: -He expected refunds to be provided to a resident or resident's family representative within 14 days from a resident's discharge when the resident or resident's family representative provided a 14-day written notice of discharge according to the facility's refund policy. -The former BOM was responsible for ensuring refunds were provided to the resident's or resident's family representatives within 14 days from the date of a resident's discharge when a resident provided a 14-day written notice. -The former BOM had not refunded Resident #2's family representative within 14 days because the BOM thought all refunds were issued within 30 days from the date of a resident's discharge. -He was aware Resident #2's family	D 430		

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D 430	Continued From page 15 representative was not refunded within fourteen days of Resident #2's discharge from the facility because the RDO arranged for the refund check to be overnighted on 08/06/24. Interview with the current Manager on 09/26/24 at 12:00pm revealed: -She was not aware Resident #2's family representative had not received a refund within 14 days from the resident's discharge. -She was aware that refunds should be provided to residents or resident's family representatives within 14 days from a discharge when the resident or resident's family representative provided a 14-day written notice according to the facility's refund policy. -She expected refunds to be provided to the residents or residents family representatives within 14 days from discharge because this was the facility's policy. A telephone interview with the former interim Manager on 09/26/24 at 12:20pm revealed: -The former BOM was responsible for ensuring refunds were provided to the resident's or resident's family representatives within 14 days from the date of a resident's discharge when a resident provided a 14-day written notice. - She was not aware Resident #2's family representative had sent a 14-day written notice of discharge on 06/28/24 because the former BOM had not included her in the email communications from the resident's family representative. -She thought Resident #2's 14-day notice was on 06/20/24 due to an email she had received from a 3rd party senior aging counseling group related to Resident #2. -She expected refunds to be processed and sent to the resident's or resident's family representatives within 14 days according to the	D 430			

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D 430	Continued From page 16 facility's written refund policy. -She was aware Resident #2's family representative had not received a refund within 14 days from discharge on 07/12/24 because she thought there were billing issues that needed to be resolved between the facility and Resident #2's family representative. A telephone interview with Resident #2's family representative on 09/26/24 at 1:00pm revealed: -He provided a 14-day written notice of discharge for Resident #2 on 06/28/24 to the facility's Sales and Marketing Director, the former Regional Director of Clinical Services (RDCS), and the facility's former Director of Clinical Services (DCS) through email communications. -He provided an email communication on 07/03/24 to the former interim Manager and RDO referencing Resident #2's 07/03/24 physical move-out and Resident #2's financial responsibility through 07/12/24. -He requested invoice copies from the BOM on 07/09/24 due the BOM had provided incorrect amounts and an incorrect financially responsible end date of 07/04/24 for Resident #2 in the BOM's previous communications. -The former BOM had not communicated with Resident #2's family representative from 07/24/24 through 08/05/24 for the refund being possibly delayed beyond the 14 days from Resident #2's discharge. -The former BOM contacted Resident #2's family representative through electronic email communication on 08/06/24 for Resident #2's family representative's physical address without explanation of the refund being delayed beyond the 14-day period of Resident #2's financially responsible end date of 07/12/24. -Resident #2's family representative received the refund on 08/19/24 through mail delivery.	D 430			

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D 430	Continued From page 17 Attempted telephone interview with the facility's former BOM on 09/26/24 at 11:10am and 2:15pm was unsuccessful. Attempted telephone interview with the former RDSC on 09/26/24 at 11:15am was unsuccessful. Attempted telephone interview with the facility's former DCS on 09/26/24 at 11:20am was unsuccessful.	D 430			