STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL073014	A. BUILDING: _____ B. WING _____	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCH OF LOVE FAMILY CARE HOME	1025 RIDE ROAD ROXBORO, NC 27573

(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 September 10, 2024.	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 Health Service Regulation, 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 Health Service Regulation 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 Health Service Regulation for review of any possible changes that may be required to	C 007		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Geraldine Zancey — TITLE: Administrator — (X6) DATE: 10/20/2024

Reviewed and acknowledged with addendums added 10/28/24 on pages 3, 10, and 17. kg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCH OF LOVE FAMILY CARE HOME	1035 RIDE ROAD ROXBORO, NC 27573

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C 007	Continued From page 1 the building.	C 007		

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 2 sampled residents who did not exit the facility during a fire drill (#2).

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 09/10/24 at 8:30am revealed five residents resided in the facility.

Review of the facility's fire rehearsal schedule revealed:
-On 07/20/24 at 1:30pm, residents were in their rooms resting after lunch when the fire alarm was activated, all the residents headed to the exit, all the residents were aware of the meeting place, and the total time for the evacuation was 2 minutes.
-On 08/18/24 at 2:00pm, a fire drill was done on a Sunday afternoon and all the residents responded in a timely manner.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCH OF LOVE FAMILY CARE HOME	1025 RIDE ROAD ROXBORO, NC 27573

(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 007	Continued From page 2 Observation of the facility on 09/10/24 at 2:39pm revealed: -Resident #2 was in her room sitting in a chair with the television on. -Resident #2's roommate was sitting in a second chair in the room. -The alarm was activated and Resident #2's roommate exited the room and went outside the front door of the facility. -Resident #2 continued to sit in her chair looking at the television. Telephone interview with the Administrator on 09/10/24 at 4:19pm revealed: -She did not know until today, 09/10/24, that Resident #2 did not leave the facility during a fire drill. -A staff member had notified her Resident #2 did not leave the facility and "just sat in her chair with her legs crossed" and the staff member did not know what was wrong with the resident. -She was at the facility on 08/18/24 when a fire drill was conducted. -She did the fire drill because she wanted to make sure Resident #2 exited the facility. -At the time of the fire drill, Resident #2 came out of her room and exited the facility through the front door. -She did not pay attention to see if Resident #2 followed another resident or not. Refer to Tag C0022 10A NCAC 13G .0302(b) Design and Construction.	C 007	Addendum 10/28/24: The Administrator will notify DHSR if any resident has a change in their condition and is determined to be non-ambulatory. Resident #2 had one ON ONE Supervision, 24 hours a day until 9-13-2024. At that time resident #2 was transfered to a memory care unit.	9-13-24
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction	C 022		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCH OF LOVE FAMILY CARE HOME	1025 RIDE ROAD ROXBORO, NC 27573

(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 022	Continued From page 3 (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 3 sampled residents (#2) who did not respond to a fire alarm. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents. Review of the facility's fire evacuation plan for residents (undated) revealed: -When the fire alarm sounded and the resident was in their room, the resident should please follow these procedures. -Feel the door to see if it was hot before opening. -If the door was not hot, close all windows and leave the room, closing the door behind them, and exit the building at the nearest exit. -If the door was hot, do not attempt to leave the room. -Turn the room light on, go to the window and stand, open the drapes, if possible, hang a sheet or towel outside the window. -Do not panic, remain in front of the window and	C 022		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCH OF LOVE FAMILY CARE HOME	1005 RIDE ROAD ROXBORO, NC 27573

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C 022	Continued From page 4 wait for a staff member and/or fire department personnel to assist. -When the fire alarm sounded and the resident was not in their room, the resident should follow these procedures. -Exit the building at the exit nearest the resident, once safely outside the building, and report to the central meeting area. Review of the facility's fire rehearsal schedule revealed: -On 07/20/24 at 1:30pm, residents were in their rooms resting after lunch when the fire alarm was activated, all the residents headed to the exit, all the residents were aware of the meeting place, and the total time for the evacuation was 2 minutes. -On 08/18/24 at 2:00pm, a fire drill was done on a Sunday afternoon and all the residents responded in a timely manner. Review of Resident #2's current FL-2 dated 07/15/24 revealed: -Diagnoses included memory impairment, hypertension, and anemia. -The resident was intermittently disoriented. Review of Resident #3's Resident Register revealed an admission date of 06/12/24. Review of Resident #2's assessment and care plan dated 07/15/24 revealed: -The resident was sometimes forgetful and needed reminders. -The resident required supervision with eating and ambulation. -The resident required limited assistance with toileting and bathing. -The resident required extensive assistance with dressing, grooming, and personal hygiene.	C 022		

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C 022	Continued From page 5 Review of Resident #2's Neurologist's after-visit summary dated 05/16/24 revealed: -The after-visit summary was in the resident's record and was documented as received on 07/09/24 by fax. -Resident #2 was being seen for memory impairment with onset around 1 year ago. -Resident #2 stated she sometimes would forget things, but not a lot. -Resident #2's family member stated the family members had been noticing a gradual change for a little over a year. -Examples given by the family member were when Resident #2 was asked questions the resident would not be able to answer them, and the resident was forgetting things. -Resident #2 knew the day but could not answer the month. -Resident #2 scored 21 out of 30 on the mini-mental exam indicating mild cognitive impairment. -Resident #2 was slow to answer and at times was slow to follow commands. Review of Resident #2's care notes revealed: -Resident #2 was admitted to the facility on 06/12/24. -On 06/24/24, Resident #2 was up through the night, wandering constantly in and out of other residents' rooms. -Resident #2 urinated in the shower and the urine smelled strong. -Resident #2 was taken to an urgent care facility for an evaluation. -On 06/28/24, a call was made to Resident #2's primary care provider (PCP) to get the results of a urinalysis. -The nurse reported there was no growth or urinary tract infection (UTI).	C 022		

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C 022	Continued From page 6 -On 07/09/24, Resident #2 was seen by the PCP and was checked for a UTI and the resident did not have a UTI. -On 08/22/24, Resident #2 was seen by the PCP and diagnosed with a UTI and started on an antibiotic for five days. -On 08/28/24, Resident #2 had finished the antibiotics but still seemed very confused and constantly going to the bathroom. -On 08/29/24, Resident #2 was seen by the PCP and was diagnosed with an ongoing UTI and was started on a different antibiotic. -On 09/03/24, Resident #2 was sitting on the sofa "throwing up" and would not answer her name; emergency medical services (EMS) were called and transported the resident to the local hospital. -On 09/03/24, Resident #2 returned to the facility with a prescription for nausea as needed. -On 09/04/24, Resident #2 had a follow-up appointment with her PCP. Interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 2:34pm revealed: -Fire drills were done every month at the facility. -Resident #2 exited the facility when a fire drill was conducted. -She did not provide any verbal or physical prompting to the residents. -She would set the fire alarm off in the hallway, and all the residents in the facility would go outside.	C 022		
	Observation of the facility on 09/10/24 at 2:3[illegible]pm revealed: Observation of the facility on 09/10/24 at 2:3[illegible]pm revealed: -Resident #2 was in her room sitting in a chair with the television on. -Resident #2's roommate was sitting in a second			

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C 022	Continued From page 7 chair in the room. -The alarm was activated and Resident #2's roommate exited the room and went outside the front door of the facility. -Resident #2 continued to sit in her chair looking at the television. Interview with Resident #2 on 09/10/24 at 2:41pm revealed: -She did not hear a fire alarm. -She thought her roommate might have gone to the store when the roommate left the room. -When asked what she would do if there was a fire, she responded she would call someone to "take it out." -She was not able to answer what take "it" out was. -When asked what she would do if the facility was on fire, she responded get out. -When asked what she would do if she heard the fire alarm, she responded that she would get in touch with someone. -When asked who "someone" was and why would she get in touch with someone, she did not respond. -Resident #2 knew her month of birth but did not know the date or year of birth. -She did not know the day of the week, the month, or the year. -She did not know the staff names at the facility or her roommate's name; "it would come back to her later." -She stated she had problems remembering but could not give any further explanation. Telephone interview with Resident #2's family member on 09/10/24 at 3:43pm revealed: -Resident #2 lived in her own home with a male friend until the family members began noticing problems with the resident.	C 022		

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C 022	Continued From page 8 -She and another family member had noticed Resident #2 seemed "off." -When she visited Resident #2 in the resident's home, the resident would look at her and it was like she was internalizing who she was. -She was concerned and made an appointment for her family member to see the PCP sometime in April 2024. -In June 2024, someone filed an Adult Protective Services (APS) report. -The APS staff moved Resident #2 from the resident's home into the facility. -She thought Resident #2 would recognize the sound of a fire alarm, especially if the facility was having fire drills. -She was concerned Resident #2 did not respond to the fire drill, today, 09/10/24. -She "really thought Resident #2 would have known how to respond." -She thought Resident #2 had been hiding how bad her memory loss was. Telephone interview with the Administrator on 09/10/24 at 4:19pm revealed: -She did not know until today, 09/10/24, that Resident #2 did not leave the facility during a fire drill. -A staff member had notified her Resident #2 did not leave the facility and "just sat in her chair with her legs crossed" and the staff member did not know what was wrong with the resident. -She was at the facility on 08/18/24 when a fire drill was conducted. -She did the fire drill because she wanted to make sure Resident #2 exited the facility. -Resident #2 was in her bedroom at the time of the fire drill, the resident came out of her room and exited the facility through the front door. -She did not pay attention to see if Resident #2 followed another resident or not.	C 022		

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C 022	Continued From page 9 Interview with Resident #2's Department of Social Services Guardian on 09/10/24 at 5:13pm revealed she had been notified Resident #2 had exited the facility on previous fire drills, but did not today, 09/10/24. Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 09/10/24 at 3:41pm was unsuccessful. The facility failed to ensure the building was in compliance with its current license for ambulatory residents resulting in a resident (#2) who had a memory impairment and was intermittently disoriented, and did not respond to the fire alarm, which could cause the resident to not be able to independently evacuate the building in an emergency such as a fire. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 09/10/24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 25, 2024.	C 022	Resident #2 had ONE ON ONE supervision 24 hours a day until 9-13-2024. 9-13-2024, at that time, Resident #2 was transfered to a memory care unit. 9-13-2024 Addedndum 10/28/24: The Administrator will ensure the facility is in compliance with the license for ambulatory residents by making sure all residents are able to independetly respond to the fire drills without verbal prompting or physical assistance.	
C 069	10A NCAC 13G .0312(g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door	C 069		

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C 069	Continued From page 10 for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 exit doors that were accessible to a resident, who was intermittently disoriented (#2), had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents. The findings are: Observation of the side entrance/exit door to the facility on 09/10/24 at various times between 8:30am-5:00pm revealed: -The door was in the living room area of the facility. -No alarm sounded when the door to the facility was opened and closed. Observation of a second entrance/exit door to the facility on 09/10/24 at various times between 8:30am-5:00pm revealed: -The door was in the living room and no alarm sounded when the door was opened and closed. -The door opened into a garage. -At 8:30am, the garage door was closed. -At 1:36pm, the garage door was opened and remained open until 4:30pm.	C 069		

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C 069	Continued From page 11 Observation of a third entrance/exit door to the facility on 09/10/24 at various times between 8:30am-5:00pm revealed the door was located in the front of the facility and no alarm sounded when the door was opened and closed. Review of Resident #2's current FL-2 dated 07/15/24 revealed: -Diagnoses included memory impairment, hypertension, and anemia. -The resident was intermittently disoriented. Review of Resident #3's Resident Register revealed an admission date of 06/12/24. Review of Resident #2's assessment and care plan dated 07/15/24 revealed: -The resident was sometimes forgetful and needed reminders. -The resident required supervision with eating and ambulation. -The resident required limited assistance with toileting and bathing. -The resident required extensive assistance with dressing, grooming, and personal hygiene. Review of Resident #2's Neurologist's after-visit summary dated 05/16/24 revealed: -The after-visit summary was in the resident's record and was documented as received on 07/09/24 by fax. -Resident #2 was being seen for memory impairment with onset around 1 year ago. -Resident #2 stated she sometimes would forget things, but not a lot. -Resident #2's family member stated the family members had been noticing a gradual change for a little over a year. -Examples given by the family member were	C 069		

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C 069	Continued From page 12 when Resident #2 was asked questions the resident would not be able to answer them, and the resident was forgetting things. -Resident #2 knew the day but could not answer the month. -Resident #2 scored 21 out of 30 on the mini-mental exam indicating mild cognitive impairment. -Resident #2 was slow to answer and at times was slow to follow commands. Review of Resident #2's care notes revealed: -Resident #2 was admitted to the facility on 06/12/24. -On 06/24/24, Resident #2 was up through the night, wandering constantly in and out of other residents' rooms. -Resident #2 urinated in the shower and the urine smelled strong. -Resident #2 was taken to an urgent care facility for an evaluation. -On 06/28/24, a call was made to Resident #2's primary care provider (PCP) to get the results of a urinalysis. -The nurse reported there was no growth or urinary tract infection (UTI). -On 07/09/24, Resident #2 was seen by the PCP and was checked for a UTI and the resident did not have a UTI. -On 08/22/24, Resident #2 was seen by the PCP and diagnosed with a UTI and started on an antibiotic for five days. -On 08/28/24, Resident #2 had finished the antibiotics but still seemed very confused and constantly going to the bathroom. -On 08/29/24, Resident #2 was seen by the PCP and was diagnosed with an ongoing UTI and was started on a different antibiotic. Interview with the Supervisor-in-Charge (SIC) on	C 069		

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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 069	Continued From page 13 09/10/24 at 1:17pm revealed: -When Resident #2 had a UTI, the resident was completely disoriented. -Resident #2 was following staff around and when she was told to sit down it was like the resident did not know how. -Resident #2 was restless, walking a lot, and she could hear her at night walking. -Resident #2 was going to the bathroom a lot and looked at the toilet but did not go. -Resident #2 was going into other resident rooms. -Resident #2 was treated for a UTI and was "getting back to herself, but not quite there yet"; she was not as talkative as she was when she first moved in. -There was usually one staff member at the facility during the day, 8:00am-3:00pm and she usually worked 3:00pm-8:00am. -Resident #2 was no longer getting up at night. -If Resident #2 went outside, she went with the resident because she was afraid the resident would walk up to the road. -She was afraid Resident #2 would get too close to the traffic. -She only turned the door alarms on at night. -If she was going to the bathroom she closed and locked the doors. -The alarms were not on during the day. -The outside garage door was kept closed. -Even if a resident went into the garage from inside the facility, the resident could not get out of the facility. Interview with a second staff member on 09/10/24 at 2:16pm revealed: -The storm doors were not always locked. -If she knew she was going to be doing resident care, she may have closed the door. -She may or may not have turned the alarms on. -If she needed to go to the bathroom, she knew	C 069		

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	FCL073014	A. BUILDING: _____ B. WING _____	09/10/2024

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C 069	Continued From page 14 where all the residents were and would just go to the bathroom. -There were no residents at the facility that she would worry about going outside. -She did not think Resident #2 would go outside unless she was with someone. -She had seen Resident #2 stand at the door looking out, but the resident never attempted to go outside. -There were door alarms were on the doors. -There was no reason they were not using the door alarms. -Resident #2 was usually in her room or the living room. -If Resident #2 was in the living room, she was usually in the room too. -She "laid eyes on all the residents off and on all day." Telephone interview with Resident #2's family member on 09/10/24 at 3:43pm revealed: -Resident #2 lived in her own home with a male friend until the family members began noticing problems with the resident. -She and another family member had noticed Resident #2 seemed "off." -When she visited Resident #2 in the resident's home, the resident would look at her and it was like she was internalizing who she was. -She was concerned and made an appointment for her family member to see the PCP sometime in April 2024. -Resident #2 only weighed 94lbs when she took her to the PCP. -An appointment was made to see a Neurologist. -In June 2024, someone filed an Adult Protective Services (APS) report. -The APS staff moved Resident #2 from the resident's home into the facility. -When she saw Resident #2 for the first time at	C 069		

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C 069	Continued From page 15 the facility, she thought it was the end of June 2024, the resident was talking about her and another family member, but it was as if the resident did not know she was one of the two family members being discussed. -She was very upset to see Resident #2 like this and was very emotional but Resident #2 did not even respond to her being emotional, "it was just not like her." -She was last at the facility on 08/31/24 and the resident still seemed confused. -When she left the facility Resident #2 tried to go with her. -She did not think Resident #2 would walk off unless the resident was going to find someone outside. -Resident #2 should be monitored if the resident went outside because the resident did not know where she was as far as location. Telephone interview with the Administrator on 09/10/24 at 4:19pm revealed: -Door alarms would be used at night if needed. -No one at the facility wandered but if the alarms were needed, the alarms were there. -She thought the alarms were turned on at 5:00pm. -The alarms were put in place for another resident a long time ago. -Resident #2 had memory loss, and APS had contacted her and needed a safe place for the resident. -Resident #2 was somewhat disoriented but not enough to be concerned the resident would walk away. Interview with Resident #2's Department of Social Services Guardian on 09/10/24 at 5:13pm revealed she did not think Resident #2 would walk away from the facility, but it was better to be	C 069		

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C 069	Continued From page 16 safe than sorry and have the door alarms on. Attempted telephone interview with Resident #2's PCP on 09/10/24 at 3:41pm was unsuccessful. The failure of the facility to ensure the alarms on the exit doors to the facility had an audible sounding device when activated resulted in a resident who had a diagnosis of memory impairment and was intermittently disoriented, having access to the doors and possibly elopping. This failure was detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 09/10/24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 25, 2024.	C 069	ALL exit doors are equipped with an Audible Sounding device when entering and exiting the facility AN audible Sounding device was installed ON the garage door ON 9-10-2024	9-10-2024
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family 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	C 315	Correction Date: 09/11/24 Addendum 10/28/24: The SIC will ensure the sounding devices are working on all the doors daily. The Administrator/Co-Owner will ensure the sounding devices are working on all the doors weekly.	

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C 315	Continued From page 17 record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to clarify orders for 2 of 3 sampled residents (#1, #3) related to an order for a supplement (#1) and an order for weights and a topical cream (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 09/05/24 revealed: -Diagnoses included congestive heart failure, hypertension, and osteopenia. -There was no order for Cholecalciferol (a vitamin D3 supplement) 50mcg once daily. Review of Resident #1's after-visit summary dated 09/05/24 revealed: -Resident #1 was seen by her primary care provider (PCP) on 09/05/24 for hypertension and to complete paperwork. -Resident #1's medication list included Cholecalciferol 50mcg once daily which was not listed on the FL-2 dated 09/05/24. -The after-visit summary was electronically signed by Resident #1's primary care provider (PCP). Review of Resident #1's September 2024 from 09/05/24-09/10/24 medication administration record (MAR) revealed: -There was no entry for Cholecalciferol 50mcg. -There was no documentation Cholecalciferol 50mcg had been administered. Observation of Resident 1's medications on hand on 09/10/24 at 9:42am revealed there was no Cholecalciferol 50mcg available to be	C 315		

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C 315	Continued From page 18 administered. Telephone interview with Resident #1's PCP's certified medical assistant (CMA) on 09/10/24 at 1:46pm revealed: -Resident #1's PCP was out of the office today, 09/10/24. -Cholecalciferol 50mcg was listed as an active medication in Resident #1's profile. -The last time a prescription was written for Resident #1's Cholecalciferol was on 05/24/24. -She was not sure if Resident #1 should be taking Cholecalciferol 50mcg or not if the medication was not listed on the FL-2. Telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:54pm revealed: -Resident #1's FL-2 dated 09/05/24 was received and there was no order for Cholecalciferol 50mcg. -She did not know if Resident #2's after-visit summary dated 09/05/24 was received at the pharmacy, but if it was, she would have only used the FL-2 because the FL-2 was considered signed orders. -If there were two orders on the same date that were not the same, she would have expected the staff at the facility to have called Resident #2's PCP for clarification and/or the pharmacy. Interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 2:56pm revealed: -She looked over Resident #1's after-visit summary dated 09/05/24. -She did not see Cholecalciferol 50mcg listed on Resident #1's after-visit summary. -If she had seen the order, she would have called the pharmacy or PCP to clarify.	C 315		

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C 315	Continued From page 19 Interview with Resident #1 on 09/10/24 at 6:09pm revealed: -She took Vitamin D (Cholecalciferol) because she did not get enough sunlight. -She did not know if the Vitamin D was in the medications she was administered daily. Refer to the telephone interview with the Administrator on 09/10/24 at 4:19pm. 2. Review of Resident #3's current FL-2 dated 08/12/24 revealed diagnosis included hypertension. a. Review of Resident #3's current FL-2 dated 08/12/24 revealed an order for Triamcinolone 0.1% cream, use daily with Eucerin cream to body including arms and legs. Review of Resident #1's August 2024 from 08/12/24-08/31/24 medication administration record (MAR) revealed: -There was no entry for Triamcinolone 0.1% cream. -There was no documentation Triamcinolone 0.1% cream had been administered. Review of Resident #1's September 2024 from 09/01/24-09/10/24 MAR revealed: -There was no entry for Triamcinolone 0.1% cream. -There was no documentation Triamcinolone 0.1% cream had been administered. Observation of Resident 3's medications on hand on 09/10/24 at 11:21am revealed there was a tube of Triamcinolone cream dispensed on 06/06/24 with the directions to use twice daily as needed (PRN) with Eucerin cream to the body including arms and legs.	C 315		

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C 315	Continued From page 20	C 315		

Telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:54pm revealed:
-Resident #3's current order for Triamcinolone was dated 05/31/24 and was to be used PRN.
-There was no documentation Resident #3's FL-2 dated 08/12/24 had been received at the pharmacy.
-If Resident #3's FL-2 had been received the pharmacy would have entered the Triamcinolone as a new order and removed the PRN order.
-If the medication was not needed daily, the facility staff could have then gotten clarification on the order.

Interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 2:56pm revealed:
-Resident #3's Triamcinolone was ordered daily a "while back" when the resident had a rash.
-The resident's rash had cleared up and the medication was changed to PRN.
-She completed Resident #3's FL-2 and failed to add PRN to the order for the Triamcinolone.
-She usually sent the FL-2 to the pharmacy.
-The order would need to be clarified.

Interview with Resident #3 on 09/10/24 at 6:09pm revealed he did not have a rash and was not itching.

Attempted telephone interview with Resident #3's PCP on 09/10/24 at 11:56am was unsuccessful.

Refer to the telephone interview with the Administrator on 09/10/24 at 4:19pm.

b. Review of Resident #3's current FL-2 dated 08/12/24 revealed:
-There was an order for Furosemide 20mg once

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C 315	Continued From page 21 daily if needed (PRN) for a weight gain of 3 pounds (lbs) a day or a weekly weight gain of 5lbs. -There was an order for weekly weights. Review of Resident #1's August 2024 from 08/12/24-08/31/24 medication administration record (MAR) revealed: -There was an entry for Furosemide 20mg once daily if needed for a weight gain of 3lbs a day or a weekly weight gain of 5lbs. -There was no documentation Furosemide had been administered PRN. -There was an entry for weekly weights. -Weekly weights were documented as 190, 189, and 190. -There was no documentation for daily weights. Review of Resident #1's September 2024 from 09/01/24-09/10/24 MAR revealed: -There was an entry for Furosemide 20mg once daily if needed for a weight gain of 3lbs a day or a weekly weight gain of 5lbs. -There was no documentation Furosemide had been administered PRN. -There was an entry for weekly weights. -Weekly weights were documented as 191 and 189. -There was no documentation for daily weights. Observation of Resident 3's medications on hand on 09/10/24 at 11:21am revealed: -There was a punch card dispensed on 08/14/23 for ten tablets of Furosemide 20mg once daily if needed for a weight gain of 3lbs a day or a weekly weight gain of 5lbs; 8 tablets were remaining. -There was a second punch card dispensed on 06/06/24 for thirty tablets of Furosemide 20mg once daily if needed for a weight gain of 3lbs a	C 315		

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C 315	Continued From page 23 -If the resident had an order to weigh the resident weekly, the staff should contact the PCP to see which order was accurate. -An order for daily weights with a medication and an order for weekly weights would be confusing. Attempted telephone interview with Resident #3's PCP on 09/10/24 at 11:56am was unsuccessful. Refer to the telephone interview with the Administrator on 09/10/24 at 4:19pm. Telephone interview with the Administrator on 09/10/24 at 4:19pm revealed: -The SIC reviewed the residents' FL-2s and after-visit summaries. -She reviewed the residents' records sometimes once a month, but at least quarterly. -She asked the SIC if she had any questions or concerns about the FL-2s and after-visit summaries. -She would have expected the SIC to have compared any new orders and if there was a discrepancy to have gotten it clarified.	C 315	Medication Staff has been inserviced on proper documentation and how to clarify Orders if any discrepancies The Sic and administrator Will check all orders daily. The facility RN Will review orders Weekly to ensure Orders are followed as ordered by the provider.	09/13/24

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