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
	FCL035021	A. BUILDING: _____ B. WING _____	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE FAMILY CARE HOME III	45 CANNADY WAY FRANKLINTON, NC 27525

(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 November 5, 2024.	C 000	Plan of Correction for Medication and Treatment Implementation To ensure that all resident medications and treatments are administered as per provider orders, including TED Hose (compression stockings), and that regular audits are conducted to verify compliance. 1. Medication Aide Self-Audit: - Responsibility: The Medication Aide on duty will perform a self-audit before the end of each shift. - Purpose: To verify that all medications and treatments have been properly administered according to provider orders. - Process:The Medication Aide will cross-check the resident's medication/ treatment administration record (MAR/TAR) to ensure accuracy and completeness.	11/11/2024
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 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 observations, interviews, and record reviews, the facility failed to ensure physicians' orders were implemented for 1 of 3 sampled residents (#2) related to an order for compression stockings. The findings are: Review of Resident #2's current FL-2 dated 07/24/24 revealed: -Diagnoses included major depression, anxiety, and dementia. -She was ambulatory. -She required assistance with bathing and dressing. Review of Resident #2's care plan dated 06/28/24 revealed: -She was independent with transfers. -She required supervision with ambulation. -She required extensive assistance with dressing and grooming.	C 249	2. Registered Nurse Monthly Audits: - Responsibility: The Registered Nurse (RN) will conduct monthly audits of all medications and treatments. - Purpose: To ensure that all medications and treatments are being administered as ordered by the provider. - Process: The RN will review MAR/TAR documentation, verify that medications and treatments are being given as prescribed, and address any discrepancies. 3. TED Hose Ordering and Communication: - Responsibility: The Medication Aide will be responsible for communicating new TED Hose orders to the pharmacy via fax. - **Process:** Upon receipt of a new order for TED Hose (compression stockings), the Medication Aide will promptly fax the order to the pharmacy for processing and delivery. 4. Administrator Monthly Audit: -Responsibility: The Administrator will perform a monthly audit to ensure that TED Hose are being applied to the residents as ordered. - **Process:** The Administrator will conduct random checks during visits to the care home to confirm that TED Hose are being worn by residents as prescribed. This will include verifying that TED Hose are on the resident's legs at the time of the check. 5. Registered Nurse Follow-Up with TED Hose Compliance: - Responsibility: The RN will follow up with specific audits for residents who have TED Hose orders. - Purpose: To verify that each resident with a TED Hose order has the stockings applied to their legs in accordance with provider instructions. - Process:The RN will review resident care records, check for the proper application of TED Hose, and document results from the monthly audit. The audits will be performed monthly until no deficits are determined and then audits will decrease to quarterly auditing by staff. 6. Documentation and Reporting: - Responsibility:The Registered Nurse will complete and document the results of the monthly audits. - Purpose: To ensure accountability and track progress in the implementation of the plan. - Process: The RN will provide the completed audit results to the Administrator on a monthly basis and then quarterly basis. The Administrator will review and take appropriate actions if any discrepancies or non-compliance are identified. Timeline for Implementation: - Immediate: Medication Aides, Registered Nurse, and Administrator have initiated performing audits as outlined. - Ongoing: Regular audits will continue on a monthly basis, with documentation provided to the Administrator for review and follow-up. Outcome: By implementing this corrective action plan, Divine FCH will ensure that all medications and treatments, including TED Hose, are properly administered and documented in accordance with provider orders, and that any discrepancies are addressed promptly to provide effiecient care.	11/11/2024 11/11/2024 11/11/2024 11/11/2024 11/11/2024 11/11/2024 11/11/2024

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Owner (X6) DATE 11/14/24

Reveiwed and Acknowledged 11/25/24

Janet Thornburg

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C 249	Continued From page 1 Review of Resident #2's physician's order dated 07/30/24 revealed an order for compression stockings. Observation of Resident #2's ankles and lower legs on 11/05/24 at 9:55am revealed: -She was seated on the couch with her legs down and feet on the floor. -She was wearing fuzzy ankle socks. -The top of the socks had caused an indention in her legs and the swelling rolled over the top of the sock. -She was not wearing compression stockings. Interview with Resident #2 on 11/05/24 at 9:55am revealed: -She had swelling in her ankles for a long time. -Her primary care provider (PCP) instructed her to keep her feet elevated when she was seated. -She did not elevate her feet when she was seated. -She did not have any special socks or stockings to wear on her legs. -She did not know if she was to wear special socks or stockings on her legs to help with the swelling. Review of Resident #2's September 2024 medication administration record (MAR) revealed: -There was no entry for compression stockings to be applied. -There was no documentation compression stockings had been applied. Review of Resident #2's October 2024 MAR revealed: -There was no entry for compression stockings to be applied. -There was no documentation compression	C 249		

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C 249	Continued From page 2 stockings had been applied. Review of Resident #2's November 2024 MAR from 11/01/24 to 11/05/24 revealed: -There was no entry for compression stockings to be applied. -There was no documentation compression stockings had been applied. Interview with the medication aide on 11/05/22 at 10:02am and 10:58am revealed: -She was not aware of any residents who had an order for compression stockings. -There was no entry on the MARs for compression stockings to be placed on every morning and removed every evening. -She faxed new orders to the pharmacy and would call to ensure the pharmacy received the faxed order. -The pharmacy was responsible for placing the order on the MAR. Interview with Resident #2's PCP on 11/05/24 at 10:39am revealed: -She ordered compression stockings for Resident #2 on 07/30/24 because of lower leg/ankle edema. -She encouraged Resident #2 to elevate her legs when seated. -She did not know the compression stockings were not being applied to Resident #2's lower extremities as ordered. -She expected the compression stockings to have been ordered and applied to Resident #2's lower extremities as ordered. -Resident #2 could have increased edema if she was not wearing the compression stockings as ordered. Telephone interview with a representative from	C 249		

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C 249	Continued From page 3 the facility's contracted pharmacy on 11/05/24 at 11:08am revealed: -The pharmacy did not have an order for compression stockings for Resident #2. -When the pharmacy received an order for compression stockings, they would fax a measurement form to the facility for the staff to obtain measurements of the residents lower legs, fax the measurements to the pharmacy and the pharmacy would dispense the correct size of compression stockings. -The pharmacy would make an entry on the MAR when they received an order for compression stockings. Telephone interview with the facility's contracted nurse on 11/05/24 at 11:01am revealed: -She did recall the order for Resident #2 to have compression stockings. -She did not realize the compression stockings had not been ordered and applied to Resident #2's lower extremities. -She must have overlooked the order. -She reviewed all orders written by the PCP. -The order should have been faxed to the pharmacy by the MA when the order was obtained for Resident #2. Interview with the Administrator on 11/05/24 at 11:30am revealed: -New orders were to be faxed to the pharmacy by the MA who received the order. -The MA should call the pharmacy to ensure the order was obtained by fax. -A copy of the order should be placed in the facility's contracted nurse's box for review. -The facility's contracted nurse would review the copy of the order with her next visit and verify the order was carried out correctly. -He expected the facility staff to follow all orders	C 249		

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