PRINTED: 03/06/2023 FORM APPROVED

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	
AND I LAN OF CONNECTION IDENTIFICATION NOWIDER.		A. BUILDING:				
FCL081047		B. WING		R-C 03/03/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
HOPE CA	RE CENTER # 1	5023 US HI				
		UNION MIL	LS, NC 28167			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	The Adult Care Licens annual and follow-up	sure Section conducted an survey on 03/03/23.				
C 320	10A NCAC 13G .1002	2 (f) Medication Orders	C 320			
	10A NCAC 13G .1002 Medication Orders					
	for medications or tre- orders and orders for	ssure that all current orders atments, including standing self-administration, are by the resident's physician oner at least every six				
	facility failed to ensure	and record reviews, the e all current orders for eents, including standing and signed by the practitioner for 3 of 3				
	The findings are:					
		t #3's current FL2 dated gnoses included elevated 19.				
	06/08/22 revealed: -There was an order f shrink an enlarged pre daily at bedtimeThere was an order f high blood sugar leve daily with foodThere was an order f	3's physician orders dated for finasteride (used to postate) 5mg 1 tablet once for metformin (used to treat lls) 500mg 1 tablet twice for polyethylene glycol (used ponstipation) mix 17gm in 8				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
FCI 004047		B. WING		R-C 03/03/2023		
FCL081047				03/03/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
HODE CA	DE CENTED # 4	5023 US H	IGHWAY 64			
HOPE CA	RE CENTER # 1	UNION MII	LS, NC 28167	,		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE	
			1	DEFICIENCY)		
C 320	Continued From page	e 1	C 320			
	The sure of the su	f				
		for pravastatin (used to treat				
	,	ng 1 tablet once daily in the				
	evening.					
		for risperidone (used to treat				
	,	ng 1 tablet every day at				
	3:00pm.	ft				
		for tamsulosin (used to treat				
		of an enlarged prostate)				
		s once daily after the same				
	•	neal each day. There was an order for trazodone (used to treat				
		•				
	depression) 50mg 1/2 bedtime.	z tablet office daily at				
		for vitamin B 12 (upped to				
		for vitamin B-12 (used to				
		3-12 levels) 1,000 mcg 1				
	tablet every other day	for Vitamin D2 1.25mg				
		treat vitamin D deficiency)				
	1 capsule once week					
	-	•				
	-There was an order for Vitamin D3 (used to treat vitamin D deficiency) 5,000 unit 1 tablet once daily. Review of Resident #3's physician order dated 07/20/22 revealed there was an order for Debrox					
	,	o remove ear wax) 5 drops				
	into each affected ear	r two times daily for 4 days.				
	Review of Resident #	3's orders revealed there				
	was no signed six-mo					
	•	tments by a prescribing				
	practitioner.	7 7 2				
	Talambana interni	with a minama aint for set the				
		with a phamacist from the				
		harmacy on 03/03/23 at				
		e latest medication and				
treatment orders signed by a prescribing						
	-	ived for Resident #3 was				
dated 06/08/22.						

Division of Health Service Regulation

STATE FORM 6899 61B911 If continuation sheet 2 of 5

Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		501004047	B. WING		R-C		
		FCL081047	B. WING		03/03/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
HODE CA	RE CENTER # 1	5023 US I	HIGHWAY 64				
HOPE CA	RE CENTER # 1	UNION M	LLS, NC 28167	•			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
C 320	Continued From page	÷ 2	C 320				
	Refer to the interview with the Supervisor-in-Charge (SIC) on 03/03/23 at 12:00pm.						
	Review of Resident #1's current FL2 dated 04/13/22 revealed: Diagnoses included depression and						
	schizophreniaThere was an order f 650mg daily.	for Tylenol (treats pain)					
	-There was an order to cholesterol) 20mg da	for atorvastatin (treats high ily at bedtime.					
	-There was an order to muscle control and sp bedtime.	for benztropine (treats pasms) 1mg daily at					
	-There was an order for cetirizine (treats allergies) 10mg daily at bedtime.						
	-There was an order for depression) 40mg da	ily.					
	-There was an order for heartburn relief 20mg twice daily.						
	-There was an order f	ation) 234mg inject					
	intramuscularly every -There was an order for (treats asthma) 10mg	for montelukast sodium					
		for omega-3 fish oil (dietary					
		for omeprazole (treats heart					
	medication) 3mg daily						
	-There was an order to depression) 100mg d	aily at bedtime.					
	supplement) 1000mc	for vitamin B-12 (dietary g daily. for ondansetron (treats					
	nausea) 4mg every 8	hours as need for nausea. for salonpas pain relief					

patch to back daily as needed for pain.

STATE FORM 6899 61B911 If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		D 0	
FCL081047		B. WING		R-C 03/03/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HOPE CARE CENTER # 1			GHWAY 64 .LS, NC 28167			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
C 320	Continued From page 3		C 320			
	Review of Resident #1's physician's orders revealed there was no six-month medical provider renewal of all medications and treatments for Resident #1. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/03/23 at 10:58am revealed the latest medication and treatment orders signed by a prescribing practitioner they received for Resident #1 was dated 05/03/22. Refer to the interview with the Supervisor-in-Charge (SIC) on 03/03/23 at 12:00pm.					
	04/13/22 revealed: -Diagnoses included: headachesThere was an order if (antipsychotic medical -There was an order if (antipsychotic medical intramuscularly every -There was an order if 500mg 2 tablets twice -There was an order if tablet daily as needed -There was an order if hours as needed for p -There was an order if constipation) 2 tables -There was an order if cream to left shoulded pain.	for fluphenazine stion) 5mg daily at bedtime. for Invega Sustenna stion) inject 117mg 28 day. for Tylenol (treats pain) e daily. for famotidine 40mg take ½ d for heartburn. for ibuprofen 600mg every 8 pain. for milk of magnesia (treats poons daily as needed. for Aspercreme with aloe of twice daily as needed for				
		2's physician's orders o six-month medical provider				

Division of Health Service Regulation

STATE FORM 6899 61B911 If continuation sheet 4 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
FCL081047		B. WING		I	R-C 03/03/2023		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
HOPE CA	RE CENTER # 1		IIGHWAY 64 LLS, NC 28167				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
C 320	renewal of all medica Resident #2. Telephone interview of facility's contracted pl 10:58am revealed the treatment orders sign practitioner they receidated 05/03/22. Refer to the interview Supervisor-in-Charge 12:00pm. Interview with the Sup 03/03/23 at 12:00pm -She had not received treatment reviews for 2022, December 202: The reviews were roprimary care provider then sent over to the residents' records. -The PCP had recent routine visits to the face	vith a pharmacist from the narmacy on 03/03/23 at a latest medication and ed by a prescribing wed for Resident #2 was with the (SIC) on 03/03/23 at a latest medication and with the (SIC) on 03/03/23 at a latest medication and residents due in November 2, and January 2023. Latinely completed by the (PCP) at a sister facility and	C 320				

Division of Health Service Regulation

STATE FORM 6899 61B911 If continuation sheet 5 of 5