

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL073012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2023</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LOVING TOUCH FAMILY CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5975 BOSTON ROAD ROXBORO, NC 27574</b>
--	--

(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 10/05/23.	C 000		
C 246	<p>10A NCAC 13G .0902(b) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews and record reviews, the facility failed to ensure health care referral and follow up for 1 of 3 sampled residents (#2) who had a referral to an oral surgeon for tooth extractions.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL-2 dated 02/28/23 revealed diagnoses included hypertension, rheumatoid arthritis, anemia, hyperlipidemia and osteopenia.</p> <p>Review of Resident #2's primary care provider's (PCP) after visit report dated 11/07/22 revealed Resident #2 had been referred to an oral surgeon due to dental decay.</p> <p>Review of Resident #2's dentist's after visit report dated 02/03/23 revealed: -She needed four teeth extracted. -She was referred to an oral surgeon in a nearby city.</p> <p>Review of Resident #2's dentist's after visit report dated 07/06/23 revealed:</p>	C 246		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL073012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2023</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LOVING TOUCH FAMILY CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5975 BOSTON ROAD ROXBORO, NC 27574</b>
--	--

(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 246	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>-Resident #2 had was seen for a follow-up cleaning to evaluate teeth and gums.</li> <li>-The resident still had teeth that need to be removed and she should see an oral surgeon for the removal.</li> <li>-The dentist instructed the facility to reach out to the office for information and recommendations for oral surgeons if needed.</li> </ul> <p>Review of Resident #2's progress notes revealed:</p> <ul style="list-style-type: none"> <li>-On 02/03/23, Resident #2 saw the dentist and was referred for extraction or surgical removal of teeth.</li> <li>-On 07/06/23, Resident #2 saw the dentist and teeth needed to be removed by an oral surgeon.</li> </ul> <p>Interviews with Resident #2 on 10/05/23 at 4:29pm and 5:19pm revealed:</p> <ul style="list-style-type: none"> <li>-She had tooth pain on both sides of her mouth.</li> <li>-She had tooth pain when she bit down on hard foods.</li> <li>-She avoided hard foods.</li> <li>-She had pain when she ate crushed pineapple a week ago; she told the Supervisor in Charge (SIC) about her tooth pain when she ate the pineapple.</li> <li>-She experienced the pain for about one year.</li> <li>-She made her own dentist appointment on 02/03/23; she thought she could have her teeth extracted at the scheduled appointment.</li> <li>-She kept a personal calendar and she had the date, 02/03/23 on the calendar.</li> <li>-The dentist told her on 02/03/23 to see an oral surgeon to have four teeth pulled because he did not remove teeth.</li> <li>-The dentist she saw on 02/03/23, wrote a referral to an oral surgeon for her; she gave the referral to the SIC.</li> <li>-The SIC saw the address on the referral was out of the area and told her there was no one to take</li> </ul>	C 246		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL073012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2023</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LOVING TOUCH FAMILY CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5975 BOSTON ROAD ROXBORO, NC 27574</b>
--	--

(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 246	<p>Continued From page 2</p> <p>her to the appointment because no one wanted to drive in the major city, and they were short staff. -After she was told there was no transportation, she did not attempt to make any more appointments with an oral surgeon; she gave up. -She wanted the facility to help her make appointments because they knew where the locations were for the oral surgeons. -If she made the appointments herself, she would not know if she would be able to get to them. -The facility staff took her to a dentist in July 2023 after she complained of tooth pain. -She did not want the dentist the facility took her to remove her teeth because she had experienced pain during a procedure prior to 2020 and she feared the same experience.</p> <p>Telephone interview with a representative from the facility's selected dental office on 10/05/23 at 4:22pm revealed: -She scheduled appointments for the dental office. -Resident #2 had been seen at the office so she would not be a new patient. -Resident #2 had an appointment with the oral surgeon scheduled for 10/31/23 at 10:00am for an exam. -Someone called today, 10/05/23 and scheduled the appointment for a consult for tooth extractions for Resident #2.</p> <p>Interview with the SIC on 10/05/23 at 1:39pm revealed: -Resident #2 had a referral from her dentist to have her teeth extracted. -Resident #2's choice dentist did not do tooth extractions and she did not want to have the oral surgeon at the dental office the facility had selected for her to see to do the extraction. -She was responsible for scheduling</p>	C 246		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL073012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2023</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LOVING TOUCH FAMILY CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5975 BOSTON ROAD ROXBORO, NC 27574</b>
--	--

(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 246	<p>Continued From page 3</p> <p>appointments.</p> <p>-She had not scheduled the appointment for the extractions yet because no one wanted to drive in the major city the referred oral surgeon was located in.</p> <p>-She tried to schedule the extraction to be done at a local dental office but Resident #2 did not want to go to the dental office the facility selected.</p> <p>-She had not stopped trying to schedule the appointment for the extraction; she last tried the first week in August 2023.</p> <p>-There were also some problems scheduling the appointment because of Resident #2's insurance.</p> <p>-Resident #2 had not complained about tooth aches.</p> <p>-Resident #2 only complained of pain when she ate something hard.</p> <p>-Resident #2 complained about pain when eating for a "long time", for several months.</p> <p>-The last time Resident #2 complained about pain when eating was about three days ago; Resident #2 was eating crushed pineapple when she complained about pain in her tooth.</p> <p>Telephone interviews with the Administrator 10/05/23 at 3:56pm and 4:39pm revealed:</p> <p>-The referring physician usually scheduled the appointments for a referral.</p> <p>-The SIC or the Administrator were responsible for making appointments for the residents.</p> <p>-When the facility had a referral for a resident, they were expected to make an appointment the same day or within a week.</p> <p>-Resident #2 made some of her own appointments; she liked being independent.</p> <p>-The SIC told her today, 10/05/23, Resident #2 had an appointment scheduled at the dental office the facility took her to; the appointment was scheduled for 10/23/23 for an evaluation.</p> <p>-She did not know who made the appointment at</p>	C 246		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL073012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2023</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LOVING TOUCH FAMILY CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5975 BOSTON ROAD ROXBORO, NC 27574</b>
--	--

(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 246	<p>Continued From page 4</p> <p>the dental office or when it was made. -She was not aware the appointment had only been made today, 10/05/23. -She did not know why Resident #2 did not want to go to the facility's dental office; she asked today, 10/05/23 but the resident did not answer. -The facility did not have a problem with transporting Resident #2 to a major city for an oral surgeon appointment if that was where she wanted to go. -Resident #2 had not complained of tooth pain to her. -It was ultimately the responsibility of the facility to ensure the appointment for the oral surgeon was made for Resident #2.</p> <p>Attempted telephone interview with Resident #2's dentist on 10/0523 at 2:55pm was unsuccessful.</p> <p>Attempted telephone interview with Resident #2's PCP on 10/05/23 at 2:56pm was unsuccessful.</p> <p>_____</p> <p>The facility failed to ensure to referral and follow up for 1 of 3 residents (#2) with repeated referrals to an oral surgeon for extraction of multiple teeth who had complained of pain when eating for almost a year. The facility failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131 D-34 on 10/05/23.</p> <p>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 19, 2023.</p>	C 246		
C 341	10A NCAC 13G .1004 (i) Medication Administration	C 341		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL073012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2023</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LOVING TOUCH FAMILY CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5975 BOSTON ROAD ROXBORO, NC 27574</b>
--	--

(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 341	<p>Continued From page 5</p> <p>10A NCAC 13G .1004 Medication Administration</p> <p>(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the documentation on the medication administration records (MARs) included the initials of the medication aide (MA) who administered the medication to three residents.</p> <p>The findings are:</p> <p>Observation of the supervisor in charge/medication aide (SIC/MA) on 10/05/23 at 9:50am revealed she was documenting medication administration on the medication administration records (MAR) for three residents.</p> <p>Interview with three residents on 10/05/23 at 8:21am and 8:50am revealed: -There were multiple staff who administered medications to them. -There was one MA who worked in the evenings and early morning and administered medications.</p> <p>Review of a three residents' medication administration records for 10/05/23 revealed the</p>	C 341		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL073012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2023</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LOVING TOUCH FAMILY CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5975 BOSTON ROAD ROXBORO, NC 27574</b>
--	--

(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 341	<p>Continued From page 6</p> <p>only one medication aide's (MA) initials documenting medication administered at 8:00am was the SIC/MAs.</p> <p>Telephone interview with a MA on 10/05/23 at 8:10am and 3:02pm revealed:</p> <ul style="list-style-type: none"> <li>-She worked third shift and administered the residents their morning medications before the SIC/MA arrived for first shift.</li> <li>-She was trained by the MA she replaced to only administer medications and not initial or document on the MAR.</li> <li>-She only documented blood pressure checks.</li> <li>-He compared the medication label to the MAR and only administered Medication to one resident at a time.</li> <li>-Someone else had always documented on the MAR for her.</li> <li>-She had been an MA for two years at another facility, she knew she was supposed to document after she administered medication but that was what was in place when she started working at the facility.</li> </ul> <p>Interview with the SIC/MA on 10/05/23 at 9:50am revealed:</p> <ul style="list-style-type: none"> <li>-The third shift MA administered all the residents their morning medications before she arrived at the facility.</li> <li>-She signed all the MARs for all the residents when she arrived in the mornings for first shift.</li> <li>-The third shift MA did not want to sign the MAR because she Did not feel comfortable finding the MAR.</li> <li>-The third shift MA was usually gone by the time she reported to work in the morning.</li> <li>-She would go around and ask the residents if they got their medication and they would say "yes."</li> <li>-She also counted the medications to see if they</li> </ul>	C 341		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL073012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2023</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LOVING TOUCH FAMILY CARE HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5975 BOSTON ROAD ROXBORO, NC 27574</b>
--	--

(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 341	<p>Continued From page 7</p> <p>had been administered.</p> <p>-She would then go document on the MAR that the medications had been administered.</p> <p>-She knew the MA who administered the medication was supposed to initial and document on the MAR, but because the MA did not want to sign the MAR, she did it for her.</p> <p>Telephone interview with the Administrator on 10/05/23 at 3:54pm revealed:</p> <p>-The MA who administered the medication was also the MA that should document on the MAR because they were the MA who insured the medication was administered correctly.</p> <p>-She looked at the MAR sometimes too see if it was documented on correctly.</p> <p>-She was not aware the SIC/MA was documenting medication administration for another MA.</p> <p>-The SIC/MA probably thought she was doing what the was best for the facility, but the SIC/MA also knew She was not supposed to document on the MAR for someone else.</p>	C 341		