STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060087	A. BUILDING: _____ B. WING _____	R-C 08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE SQUARE	5820 CAMEL ROAD CHARLOTTE, NC 28226

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual and follow-up survey and complaint investigation on 08/20/19-08/22/19 with an exit conference via telephone on 08/23/19. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 07/24/19.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to provide supervision for 1 of 8 sampled residents, according to their current symptoms, (Resident #5), with a diagnosis of dementia and a history of repeated falls, with 5 falls from 07/15/19 through 07/29/19, resulting in a lumbar compression fracture. Review of Resident #5's current FL2 dated 06/25/19 revealed: -Diagnoses included Alzheimer's dementia, visual hallucinations and auditory hallucinations.	D 270		

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-Resident #5 was ambulatory with a walker and had wandering behaviors.
-She required assistance with bathing and dressing and was incontinent of bowel and bladder.

Review of Resident 5's current Assessment and Care Plan dated 06/24/19 revealed:
-Resident #5 had "no problems with ambulation and locomotion" and did not indicate Resident #5 used any ambulatory devices.
-Resident #5 required supervision by the staff while ambulating and when transferring.
-Resident #5 was incontinent of bowel and bladder.
-Resident #5 required extensive assistance with toileting, bathing, dressing and personal hygiene.

Review of Resident #5's current Service Plan dated 06/24/19 revealed:
-Resident #5 was diagnosed with Alzheimer's Dementia and resided in the Memory Care Unit.
-Resident #5 was frequently disoriented and required verbal prompts and directions.
-Resident #5 did not require hands on assistance with mobility or ambulation.
-Bathing level of assistance (hands on assistance) was not required for Resident #5.
-Resident #5 required stand by assistance with transfers, no hands on assistance needed.
-Resident #5's "Fall Potential" indicated there were no falls within the past 90 days.
-Resident #5 was adequate with or without devices in her bedroom.
-The Falls Management Intervention option, that was identified for Resident #5, was "a physician evaluation and labs checking for urinary tract infection (UTI) or blood testing".
-The current Service Plan was signed on 06/24/19 by the Wellness Director (WD) and on

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07/01/19 by the Administrator.
-The Service Plan was not signed by Resident #5's Primary Care Physician (PCP).

Review of the facility's Falls Management Handbook revealed:
-Memory Care residents were considered at risk for falls.
-An assessment was not necessary unless needed to identify appropriate interventions due to falls.

Interview with a medication aide (MA) on 08/23/19 at 11:00am revealed:
-Resident #5 only fell once on her shift (first shift) when she worked.
-The SCU Coordinator or the MA would report the personal care needs, and levels of supervision, of the residents to the PCAs during shift report.
-When a new resident arrived on the Special Care Unit (SCU), the SCU Coordinator or the MA would report to the staff the personal care needs, and levels of supervision, required for the new resident.
-She was informed of a new resident's personal care and supervision requirements at shift report the next time she worked after the resident arrived at the SCU.
-The MAs and the PCAs did not review the residents' Care Plans.
-The staff was instructed by the SCU Coordinator to provide stand by assistance to Resident #5 when she ambulated, and to remind her to ambulate with her walker.
-Resident #5 frequently ambulated without her walker and without stand by assistance from the staff.
-Resident #5 would often get up and walk while staff were assisting other residents.
-When a resident fell, the MA assessed the

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resident for injuries, took vital signs and completed the Incident Report.
-The information regarding the fall was faxed to the PCP and the family was informed by telephone of the incident.
-The MA documented the incident in the progress notes.
-The directive from management regarding Resident #5's falls was to provide stand by assistance when she ambulated with her walker.
-Residents in the SCU were monitored by staff every 2 hours.
-There were no additional directives from management in regards to the level of supervision staff should provide Resident #5.

Interview with a PCA on 08/22/19 at 11:20am revealed:
-We received information on each resident at the shift report from the MA or the SCU Coordinator.
-Resident #5 needed hands on assistance with her ADLs and transfers.
-Resident #5 had to be "in your sight" because she would get up quickly and walk without her walker.
-We checked on residents every 2 hours, but we tried to keep Resident #5 in the common area since she was a fall risk.
-We were instructed by the MAs and the SCU Coordinator to provide stand by assistance when Resident #5 ambulated, and to remind her to ambulate with her walker.
-There were no additional directives from management in regards to increasing the supervision or monitoring of Resident #5.

Interview with the SCU Coordinator on 08/22/19 at 11:45am revealed:
-Resident #5 was on a routine 2-hour checks by the staff, as were the other residents.

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D 270	Continued From page 4 -Resident #5's supervision checks had not been increased due to her falls because she was always out in the common areas where she could be seen. -The SCU Coordinator instructed the staff to provide stand by assistance when Resident #5 ambulated, and to remind her to use her walker. -The staff tried to remind Resident #5 to ambulate with her walker, but Resident #5 often moved very quickly. -Residents with dementia would often forget safety instructions and ambulated without their assistive devices or staff assistance. "We could not supervise residents one on one." -Resident #5 required supervision and hands on assistance with personal care, showering, dressing and incontinent care. Review of Resident #5's accident/injury reports, charting notes, and hospital records revealed: -Resident #5 had 6 documented falls from 05/29/19 through 07/29/19. -Five of the six falls occurred from 07/15/19 through 07/29/19. -The resident went to the emergency department (ED) for evaluation of injuries for 1 of the falls. -The resident's injuries included a skin tear on the elbow (05/29/19), a lumbar compression fracture (07/27/19) and a bruised right eye (07/29/19). -There was no documentation of increased monitoring or supervision after any of Resident #5's falls. Review of Resident #5's Incident Report dated 05/29/19 at 10:00pm revealed: -The resident was found, by a staff person, on the floor beside the bed in her room. -There was a skin tear on her right elbow. -There was no documentation the physician was notified.	D 270		

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-The Fall Investigation form identified the root cause of the fall as "the resident was new to the facility."
-The intervention implemented was to educate the resident on the use of the call bell and assistive device (the walker).

Review of Resident #5's Incident Report dated 07/15/19 at 2:35pm revealed:
-A staff person was assisting Resident #5 with toileting when she lost her balance and fell to the floor.
-There was no apparent injury.
-There was documentation the responsible party and PCP were notified of the incident.
-There was documentation therapy to evaluate and treat for strengthening was documented as an intervention.

Review of Resident #5's Incident Report dated 07/21/19 at 5:45pm revealed:
-A staff person was assisting Resident #5 with toileting when she lost her footing and fell to the floor.
-There was no apparent injury, and no documentation vital signs were obtained.
-There was no documentation the physician was notified.
-The Fall Investigation form identified the root cause of the fall as "the resident losing her balance."
-There was documentation of 2 interventions; therapy to evaluate Resident #5 and treat for strengthening and the staff would be educated on safe transfers.

Review of Resident #5's Incident Report dated 07/26/19 at 3:27pm revealed:
-Resident #5 was found by staff sitting in front of the dining room door.

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D 270	Continued From page 6 -There were no injuries noted and no vital signs were documented. -There was no documentation the PCP was notified of the incident. -There were no interventions documented. Review of Resident #5's progress note dated 07/27/19 at 8:14am revealed: -Resident #5 was observed on the floor of her room by a staff person. -The paramedics were contacted and Resident #5 was transported to the hospital. -The responsible party was contacted and requested a meeting to discuss Resident #5's plan of care. Review of Resident #5's hospital Emergency Department (ED) discharge notes dated 07/28/19 revealed: -Resident #5 was seen for a fall on 07/27/19 at 9:01am. -The discharge diagnosis was a compression fracture of L1 lumbar vertebrae. -Hospice evaluation was recommended. Review of a Physician Visit Sheet dated 07/29/19 revealed a verbal order received by the Wellness Director (WD) for a referral of Resident #5 to Hospice for evaluation and admittance. Review of Resident #5's progress note dated 07/29/19 at 7:25am revealed: -Resident #5 was found by staff on the floor at her bedside. -There were no apparent injuries. -There was documentation the responsible party and the PCP were notified. -There was no documentation of additional interventions.	D 270		

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D 270	Continued From page 7 Review of Resident #5's Incident Reports revealed: -There was no report completed for Resident #5's fall on 07/27/19. -There was no report completed for Resident #5's fall on 07/29/19. Interview with the Hospice nurse on 08/22/19 at 11:40am revealed: -Resident #5 was admitted to Hospice on 07/30/19. -The admitting diagnosis was Alzheimer's dementia. -The responsible party and the hospital staff, during a recent hospital stay (07/27/19) with a compression fracture from a fall, had determined the resident should request a hospice evaluation for admittance when she returned to the facility. -Hospice had provided Resident #5 with a high back wheelchair, a hospital bed which could be lowered and locked for safety and a fall mat for the floor beside the bed. Interview with the Administrator on 08/22/19 at 2:00pm revealed: -Residents were assessed as to their risk of falling. -Residents who were identified as a fall risk had a Falls Management Intervention Option form completed. -This form identified interventions that would be put in place to reduce the risk of falls, or injuries with falls. -It was the policy of the facility to identify all dementia residents as fall risks. -She did not know that a Falls Management Intervention Option form had not been completed for Resident #5. -This would be completed by the Wellness Director (WD).	D 270		

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D 270	Continued From page 8 -Increased supervision, assistive devices, padded hipsters, and a sitter were some of the interventions suggested. -Usually after a third fall the family was contacted and the need for a private sitter was discussed. -She did not know why the responsible party had not been contacted regarding a sitter. -The SCU Coordinator would be responsible, with the WD, for family care meetings. -If a resident had a fall, the MA assessed the situation and checked the resident's vital signs. -If there was obvious pain, blood, or injury, emergency medical services (EMS) would be called. -An Incident Report was completed by the MA, and the family contacted. -A FAX was sent to notify the PCP of the incident and the MA documented the circumstances of the incident in the progress notes. -The WD should be notified of all incidents. -She did not know there was no Incident Report for Resident #5 on 07/27/19 or 07/29/19. -She did not know Resident #5's Service Plan did not document her assessment as hands on assistance for personal care, showering, dressing and incontinence care, or for stand by assistance with ambulation using a walker. -She thought there was enough supervision of the residents in the SCU as an Assisted Living facility required. -They could not provide one on one care to residents and it was stated in their admission packet. Telephone interview with the PCP on 08/22/19 at 3:00pm revealed: -She was notified of Resident #5's falls on 07/23/19 and 07/28/19. -She was not notified by the facility staff of the other falls.	D 270		

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-The PCP ordered the PT and OT evaluation when she visited the resident "around the middle of the month."
-She ordered the PT/OT to reduce the risk of falls.
-When Resident #5 was in the hospital (07/27/19) she had discussed with the POA the benefit of having an evaluation for Hospice admission.

Interview with the Wellness Director (WD) on 08/22/19 at 3:15pm revealed:
-The SCU Coordinator submitted all Incident Report forms to the WD and the Administrator.
-The WD did not know Resident #5 was a fall risk when she assessed her prior to admission.
-She did not know the Falls Management Intervention Option form had not been completed for Resident #5.
-She could not remember if she or the SCU Coordinator was responsible for completion of the Fall Intervention Options form for Resident #5.
-She discussed with the hospital discharge staff, a referral to Hospice for Resident #5.
-She requested a referral to PT/OT for Resident #5.
-She did not know other interventions were not implemented for Resident #5.
-She did not know why other fall intervention options were not implemented for Resident #5, such as increased supervision and monitoring.
-It would be the responsibility of the SCU Coordinator to discuss with her the need for additional interventions for residents with repeated falls.
-Interventions from the Falls Option form should have been discussed and implemented.

Based on observations and record review, Resident #5 was not interviewable.

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D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure referral and follow-up to meet the acute healthcare needs for 2 of 7 sampled residents related to a resident who presented with lethargy, decreased appetite and a change in her ability to ambulate independently (Resident #2), and a second resident who had blood pressures that were not within normal limits (Resident #1). The findings are: 1. Review of Resident #2's current FL-2 dated 06/25/19 revealed: -Diagnoses included Alzheimer's disease. -Resident #2 was semi-ambulatory with no documentation of what assistive device was needed. Review of Resident #2's Care Plan dated 03/06/19 revealed Resident #2 required	D 273		

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supervision for transfers, limited assistance with ambulation, extensive assistance with toileting, and extensive assistance with eating.

Interview with the Wellness Director (WD) on 08/22/19 at 11:35am revealed:
-She was a Registered Nurse (RN) and provided oversight to the medication aides (MA) and personal care aides (PCA) in the Special Care Unit (SCU) and Assisted Living Facility (ALF).
-She considered anything outside a resident's normal behavior to be an acute change of condition, including a resident who normally gets out of bed and refuses to do so, a resident who normally ambulates independently needing to use a wheelchair, and abnormal vital signs.
-If a MA observed a resident acting outside of their normal behavior, they were responsible for contacting her if she was in the building so she could assess the resident.
-If she was not in the building, she was on call 24 hours a day, 7 days a week and the MAs should call her.
-If the MAs could not reach her, they should immediately contact the resident's Primary Care Provider (PCP), or if they felt a resident needed immediate care, they should call Emergency Medical Services (EMS).
-She had provided written guidelines to the MAs in April or May 2019 on "Resident Conditions Requiring Nurse Notification."
-Some of the conditions listed requiring nurse notification were "resident not coming out to meals/activities, loss of energy, in bed all day; blood sugars above 400 or below 70; sluggishness/very tired, unable to stay awake; change in balance, walking ability, joint pain, new shuffle, and systolic blood pressure (SBP) greater than 180."
-She was on a leave of absence in July 2019.

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D 273	Continued From page 12 -The SCU Coordinator was responsible for providing oversight to the MAs and PCAs in her absence. -Because the SCU Coordinator was not a RN, she had instructed her to have the MAs contact the residents' PCPs or EMS for healthcare needs. -Resident #2 would intermittently refuse to eat breakfast. -Resident #2 would occasionally refuse to eat lunch. -It would not be unusual for Resident #2 to remain in the bed until around 10:00am, but it would be unusual for her to want to remain in bed until 1:30pm. -Resident #2 normally ambulated independently with a rollator walker and being so weak she required a wheelchair was not normal for her. -Resident #2 wanting to remain in bed beyond 10:00am and requiring a wheelchair should have alerted staff that something might be going on with her, and they should have checked her vital signs and notified her PCP. -The SCU staff should know their residents' baselines and be able to identify anything outside of their normal behavior. Review of the training document "Resident Conditions Requiring Nurse Notification" revealed: -"Care Partner/Direct Care Staff are to contact a nurse in the following situations involving any significant change in a resident's condition, such as below, and if there is ANY doubts as to the seriousness of the situation." -"Below are observations that can be made by unlicensed staff. Unlicensed staff may observe (use the senses to get information) and report only; they may not assess (interpret and draw conclusions from observations)." -The "following situations" included "refusing food	D 273		

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or fluids, change in vital signs, not coming out to meals/activities, loss of energy, in bed all day, blood sugars above 400 or below 70, change in balance, walking ability, sluggishness/very tired, unable to stay awake, SBP less than 90 or greater than 180."
-In an emergency, "call 911 and then notify the nurse."
-"Situations considered emergencies" included "resident becomes unable to more [move] one or more limbs" and "resident appears to have suffered a stroke (garbled speech, on [one] sided weakness, or paralysis."

Review of the facility's policy on health monitoring and intervention revealed:
-"Employees should monitor the resident for changes in his/her status on an ongoing basis and report to the Wellness Director and or the ED [Administrator] any changes noted."
-Examples of changes included "increased unsteadiness and difficulty with balance, complaints of not feeling well, a change in appetite, and a change in "energy level."
-"ANY CHANGE-EVEN A SMALL DEVIATION-FROM NORMAL FOR A RESIDENT MUST BE REPORTED TO THE WELLNESS DIRECTOR AND/OR EXECUTIVE DIRECTOR."

Interview with a SCU morning shift PCA on 08/21/19 at 2:11pm revealed:
-She was Resident #2's morning shift PCA on 07/06/19.
-She started her rounds around 7:30am on 07/06/19 and observed Resident #2 lying in bed.
-Resident #2 complained of being sleepy and wanted to stay in bed.
-Resident #2 refused to go to the dining room for breakfast.
-At 9:00am, she asked Resident #2 again if she

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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
D 273	Continued From page 14 wanted to go to the dining room for breakfast and she refused. -She did not see a breakfast tray in Resident #2's room and did not see her eat. -She continued to check on Resident #2 at least every two hours throughout her shift and thought she documented the checks on the "Continence and Incontinence Program" sheet. -She kept going back to Resident #2's room because she thought her behavior was unusual. -Resident #2 would normally be sitting in the common living area when she arrived for her morning shift. -Resident #2 would normally ambulate independently with her rollator walker to the dining room for all meals. -She went to Resident #2's room around 12:00pm or 12:30pm and Resident #2 again refused to get out of bed and refused to eat lunch. -Resident #2 complained of being sleepy and asked to be left alone. -At around 1:30pm, she helped Resident #2 transfer out of bed and ambulate with her rollator walker to the bathroom because it was almost time for the evening shift staff to arrive, and she was not allowed to leave residents in the bed. -Resident #2 had been in bed from the beginning of her shift (7:30am) until 1:30pm and that was not normal for her. -Resident #2 was too weak to continue ambulating with her rollator walker so she transferred her to a wheelchair and pushed her to the common living area. -Around 2:00pm, she asked the morning shift MA to assess Resident #2. -She did not see the MA assess Resident #2, but the MA told her she was "alright." -Her shift ended at 3:00pm and Resident #2 remained in the wheelchair in the common living area.	D 273		

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D 273	Continued From page 15 Interview with a SCU morning shift MA on 08/21/19 at 1:47pm revealed: -She was Resident #2's morning shift MA on 07/06/19. -She arrived for her shift at 6:45am. -When she arrived, Resident #2 was lying in bed. -Resident #2 refused to get out of bed and refused to go to the dining room to eat breakfast. -She administered Resident #2's morning medications and took a breakfast tray to her room. -Resident #2 ate approximately 50% of her breakfast. -On 07/06/19 was the first day she had ever taken a meal to Resident #2's room because she refused to get out of bed and go to the dining room. -Resident #2 usually "ate well." -Resident #2 could normally transfer out of bed independently and ambulate to the dining room with her rollator walker. -She checked on Resident #2 after the breakfast meal service and Resident #2 seemed "fine" but still refused to get out of bed and complained of being sleepy. -Resident #2 did not complain of any pain and was able to speak normally. -She saw Resident #2 again during the lunch meal service and she was sitting in a wheelchair. -She did not know if Resident #2 had eaten any lunch. -She thought Resident #2 was in a wheelchair because she felt tired. -She thought the PCA put Resident #2 back in bed around 1:00pm. -Her shift ended in the SCU at 3:15pm, and she went to the ALF building to work the evening shift. -She did not see Resident #2 again, after 1:00pm and before the end of her shift in the SCU.	D 273		

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-She missed a phone call from the SCU evening shift MA so she went back to the SCU around 6:00pm or 6:30pm.
-The SCU evening shift MA wanted to know if there had been anything wrong with Resident #2 during the MA's morning shift.
-She and the SCU evening shift MA observed Resident #2 to have a facial droop and was acting confused so they called EMS.

A second interview with the morning shift MA on 08/22/19 at 10:47am revealed:
-She did not check Resident #2's vital signs during her shift on 07/06/19.
-She did not have a reason to check Resident #2's vital signs because she thought Resident #2 was just tired.
-She did not recall the PCA asking her to assess Resident #2.
-She did not attempt to contact the WD, SCU Coordinator, or Resident #2's PCP.

Interview with an evening shift MA on 08/21/19 at 3:31pm revealed:
-She was Resident #2's evening shift MA on 07/06/19.
-She arrived for her shift at 3:00pm and observed Resident #2 sitting in a wheelchair in her room.
-Resident #2 was able to speak normally and had no complaints.
-Either she or a PCA (she could not remember who) pushed Resident #2 in the wheelchair to the common living area.
-It was unusual for Resident #2 to be in a wheelchair rather than ambulating with her rollator.
-She asked another staff member (she could not remember who) why Resident #2 was in a wheelchair, and she could not remember their response, but she "kept an eye on her" while she

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was in the common living area.
-The evening shift PCA pushed Resident #2 to the dining room for dinner.
-While in the dining room, Resident #2 complained to her of having right sided pain, was unable to lift her spoon, and did not eat.
-She pushed Resident #2 out of the dining room and into an adjoining hallway where she then observed her to have a facial droop.
-She called EMS around 6:00pm or 6:30pm.
-She did not check Resident #2's vital signs during her shift or contact her PCP because none of the morning shift staff had reported anything out of the ordinary for Resident #2.

Telephone interview with Resident #2's family member on 08/21/19 at 10:25am revealed:
-She visited the facility every day or at least every other day.
-On 07/06/19 at 6:45pm, she received a phone call from the facility alerting her Resident #2 had been transported to the local hospital via EMS.
-Resident #2 was diagnosed with having a stroke.
-Resident #2 spent two weeks in the hospital, was then transferred to an inpatient rehabilitation facility and was now in a Skilled Nursing Facility (SNF) because of the stroke.
-The evening shift MA who phoned her, reported when she arrived at work, Resident #2 was sitting in a wheelchair.
-The MA reported Resident #2 had refused to get out of bed for most of the day, and she did not eat breakfast, lunch or dinner.
-Resident #2 could normally transfer out of bed independently and ambulate independently with the assistance of a rollator walker.
-Resident #2 did not require the use of a wheelchair and did not own one.
-Resident #2 was typically out of bed before breakfast, ate breakfast in the dining room,

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remained in a common area of the SCU for most of the day, and ate lunch and dinner in the dining room.
-She had visited Resident #2 on 07/04/19 and 07/05/19 and there was nothing unusual about her behavior.
-She was concerned because the facility did not seek medical care for Resident #2 earlier in the day on 07/06/19.

Review of Resident #2's EMS report dated 07/06/19 revealed:
-EMS was called to the facility at 6:28pm for a possible CVA (cerebrovascular accident/stroke).
-EMS arrived at the facility at 6:43pm, and the fire department was already on scene.
-Resident #2 was found to have right sided weakness, facial droop and difficulty speaking.
-Resident #2's blood sugar was 55 (normal blood sugar range for someone without diabetes is 70-139).
-Resident #2's blood pressure was 180/110 (normal blood pressure is less than 120/80).
-EMS left the facility with Resident #2 at 6:54pm.

Review of Resident #2's progress notes dated 07/06/19 at 7:30pm revealed:
-Resident #2 was observed by a MA in the dining room and could not raise her right hand to eat.
-Resident #2 told the MA her right side was hurting.
-The MA did an "assessment" of Resident #2, called the "nurse manager" of the facility, and left a message.
-The MA called EMS and Resident #2 was transported to the Emergency Department (ED) of the local hospital.
-Resident #2's family was notified.

Review of Resident #2's incident report dated

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07/06/19 revealed:
-The time of the incident was documented as 6:00pm.
-There was documentation Resident #2 was in the dining room, during dinner, and complained her right side was hurting.
-There was documentation Resident #2 could not raise her right hand to eat.
-The MA called 911 and Resident #2 was transferred to the local hospital at 7:30pm.
-A voicemail message was left for the WD.
-Resident #2's daughter was notified and met her at the ED.
-A fax was sent to Resident #2's PCP notifying her of the incident.
-The outcome was documented as Resident #2 being hospitalized, diagnosed with a cerebrovascular accident (CVA-stroke) and discharged from the hospital to a SNF.

Review of Resident #2's "Continence and Incontinence Program" sheet dated 07/01/19-07/06/19 revealed:
-From 07/01/19-07/05/19, there was documentation Resident #2's incontinent brief was changed every two hours from 7:00am-6:00am daily.
-On 07/06/19, there was documentation Resident #2's incontinent brief was changed at 7:00am, 9:00am, 11:00am, 12:00pm and 1:00pm.
-There was no documentation, Resident #2's incontinent brief was changed after 1:00pm on 07/06/19.

Telephone interview with Resident #2's Nurse Practitioner (NP) on 08/21/19 at 4:30pm revealed:
-She provided primary care to Resident #2 and saw her on an as needed basis.
-It would be unusual for Resident #2 to not ambulate using her rollator walker to the dining

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room for breakfast.
-It would be unusual for Resident #2 to refuse to get out of bed.
-It would be unusual for Resident #2 to not ambulate using her rollator walker to the dining room for lunch.
-It would be unusual for Resident #2 to be so weak she required a wheelchair for ambulation.
-All these observations should have alerted facility staff that something was "not normal" with Resident #2.
-She expected staff to notify her immediately of anything outside a resident's normal behavior.
-If her office had been notified of Resident #2's behavior, they would have instructed the MAs to check Resident #2's vital signs and would have educated them on "red flags" of a stroke to watch for, such as slurred speech and facial drooping.
-Resident #2 had a history of hypertension, but it was controlled without blood pressure medications.
-Resident #2 did not have a history of diabetes or hypoglycemia.
-If the MAs had detected Resident #2's SBP was elevated or her blood sugar was low earlier in the day, she could have instructed them to call EMS sooner than they did.
-Stroke treatment should be addressed quickly; "the sooner the better."
- "Time is always of the essence [during a stroke] to reduce the loss of brain tissue."

Review of Resident #2's hospital discharge summary dated 07/16/19 revealed:
-On 07/06/19, Resident #2 was found by facility staff to have right-sided weakness and was unable to feed herself at dinnertime.
-When EMS arrived at the facility, Resident #2's blood sugar was 55 and SBP was greater than 200.

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-Resident #2 was diagnosed with a left thalamic infarct (a stroke that occurs in the part of the brain that involves speech, memory, balance, motivation and sensations of physical touch and pain).
-Resident #2 was hospitalized from 07/07/19 to 07/16/19.
-Physical therapy (PT) and occupational therapy (OT) were consulted, and they recommended Resident #2 be transferred to a rehabilitation facility.
-Resident #2 was discharged to a SNF on 07/16/19.

Interview with the SCU Coordinator on 08/21/19 at 3:53pm revealed:
-SCU residents should be checked on every hour by the PCAs.
-SCU residents should be checked on every two hours by the MAs and the checks documented, but she could not locate the sheet MAs were supposed to use to document the checks.
-If a PCA found a resident to not be feeling well, they should report it to the MA.
-If a MA found a resident to be acting differently than their normal, they should check the resident's vital signs, and notify the resident's PCP and their responsible party (RP).
-She did not work on 07/06/19 when Resident #2 was sent to the ED, but she was notified via phone by the evening shift MA around 7:00pm.
-She did not think it was unusual for Resident #2 to act sleepy and lethargic.
-Resident #2 did not own a wheelchair and normally ambulated using a rollator walker.
-She did not know why the MAs had not taken Resident #2's vital signs or notified her PCP or RP until after EMS transported her to the ED.

Interview with the Administrator on 08/22/19 at

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D 273	Continued From page 22 1:30pm revealed: -She considered a resident who was normally independent with walking and suddenly needing a wheelchair for ambulation or a resident with a blood sugar level or blood pressure level spiking too low or too high to all be an acute change of condition for a resident. -If a resident was generally not feeling well, she expected MAs to check their vital signs and notify the WD and the PCP. -MAs did not have the ability to assess a resident so they would need to notify the WD and PCP if a resident had a change in their condition. -If the MAs could not reach the WD, they should notify her (the Administrator). -If the MAs were ever in doubt about a resident's condition, they should call EMS. -She did not think it was unusual for Resident #2 to want to remain in bed on 07/06/19, but when Resident #2 was too weak to ambulate independently and was transferred to a wheelchair (around 1:30pm), the MAs should have notified Resident #2's PCP and obtained further instructions. 2. Review of Resident #1's current FL-2 dated 02/22/19 revealed: -Diagnoses included diabetes mellitus, vitamin B12 deficiency, hypertension, cardio-vascular disease, and abnormal gait. -There was an order for her blood pressure to be checked daily. Review of Resident #1's resident record revealed: -There was a physician's order dated 04/25/18 for Resident #1's blood pressure to be checked daily and to notify the physician if Resident #1's systolic blood pressure (SBP) was above 180 or below 100. -There was no documentation of Resident #1's	D 273		

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physician being notified of SBP readings above 180 or below 100 between 07/01/19 and 07/31/19.

Review of Resident #1's July 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for Resident #1's blood pressure to be checked daily and to notify her physician for a SBP greater than 180 or less than 100.
-On 07/08/19, there was documentation Resident #1's blood pressure reading was 94/58.
-On 07/25/19, there was documentation Resident #1's blood pressure reading was 187/88.
-There was no documentation, Resident #1's physician had been notified of blood pressure readings outside the ordered parameters for 2 of 31 opportunities.

Telephone interview with Resident #1's physician on 08/21/19 at 4:30pm revealed:
-Resident #1 had a history of unstable blood pressure readings.
-She had ordered Resident #1's blood pressure to be checked daily with parameters for the facility staff to contact her if Resident #1's SBP was above 180 or below 100.
-She had no record of facility staff reporting to her Resident #1's blood pressure reading of 94/58 on 07/08/19 or Resident #1's blood pressure reading of 187/88 on 07/25/19.
-She expected facility staff to communicate Resident #1's blood pressure readings immediately to her if Resident #1's SBP was above 180 or below 100.
-If she had known Resident #1's SBP was above 180 or below 100, she would have reassessed Resident #1's medication orders.
-If facility staff had communicated Resident #1's

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SBP reading less than 100 on 07/08/19, she would have completed an onsite assessment of Resident #1 on 07/09/19.
-If facility staff had communicated Resident #1's SBP greater than 180 on 07/25/19, she would have had her colleague complete an onsite assessment of Resident #1 on 07/26/19.
-She was not aware of Resident #1 having any hypertension or hypotension related medical events requiring medical attention in July 2019.

Interview with a medication aide (MA) on 08/22/19 at 10:40am revealed:
-She was responsible for obtaining Resident #1's blood pressure daily.
-She documented Resident #1's blood pressure results on the eMAR.
-Resident #1's physician had ordered the facility to report Resident #1's blood pressure readings if the SBP was above 180 or below 100.
-She was responsible for sending a facsimile to Resident #1's physician if Resident #1's SBP reading was above 180 or below 100.
-She had documented Resident #1's blood pressure reading as 187/88 on 07/25/19.
-She did not recall sending a facsimile to Resident #1's physician on 07/25/19.
-Resident #1 would have been added to the physician's list of residents to be seen on the next weekly physician's visit to the facility if Resident #1's physician had been notified of Resident #1's 07/25/19 blood pressure reading.
-She did not recall if Resident #1 had been seen by the facility physician on or about 07/25/19.

Interview with a second MA on 08/22/19 at 3:05pm revealed:
-She was responsible for obtaining Resident #1's blood pressure daily.
-She documented Resident #1's blood pressure

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results on the eMAR.
-Resident #1's physician had ordered the facility to report Resident #1's blood pressure readings if the SBP was above 180 or below 100.
-She was responsible for sending a facsimile to Resident #1's physician if Resident #1's SBP reading was above 180 or below 100.
-She had documented Resident #1's blood pressure reading as 94/58 on 07/08/19.
-She did not recall sending a facsimile to Resident #1's physician on 07/08/19.
-Resident #1 would have been added to the physician's list of residents to be seen on the next weekly physician's visit if Resident #1's physician had been notified of Resident #1's 07/08/19 blood pressure reading.
-She did not recall if Resident #1 had been seen by the facility physician on or about 07/08/19.

Interview with the Wellness Director on 08/20/19 at 3:34pm revealed:
-Resident #1 had an order for her blood pressure to be checked daily and to notify Resident #1's physician if Resident #1's SBP was above 180 or below 100.
-Resident #1's blood pressure readings were documented on the eMAR.
-She expected MAs to perform blood pressure checks.
-She expected MAs to document Resident #1's blood pressure results on the eMAR.
-She expected MAs to notify Resident #1's physician if her SBP was above 180 or below 100.
-MAs were expected to send a facsimile to Resident #1's physician immediately with a SBP reading above 180 or below 100.
-Facsimiles were kept in resident records.
-Resident #1's SBP was documented as 94/58 on 07/08/19.

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D 273	Continued From page 26 -Resident #1's SBP was documented as 187/88 on 07/25/19. -There was no documentation of the MAs notifying Resident #1's physician of the SBP readings on 07/08/19 or 07/25/19. Interview with the Administrator on 08/22/19 at 11:15am revealed: -MAs were responsible for checking residents' blood pressure. -She expected MAs to record Resident #1's blood pressure results on the eMAR. -She expected MAs to notify Resident #1's physician if her SBP was above 180 or below 100. -She did not know MAs had not notified Resident #1's physician on 07/08/19 when her SBP reading was 94/58. -She did not know MAs had not notified Resident #1's physician on 07/25/19 when her SBP reading was 187/88. The failure of the facility to notify the physician when Resident #2 was experiencing significant changes in condition, including lethargy, loss of appetite and a change in her ability to ambulate independently resulted in delaying treatment for Resident #2 who suffered a stroke which resulted in a hospitalization as well as a permanent change to a higher level of care. This failure resulted in substantial risk for physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/22/19. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 22, 2019.	D 273		

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D 276	Continued From page 27	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .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, record reviews and interviews, the facility failed to implement treatments as ordered for 1 of 7 sampled residents (Resident #7) who was ordered a dressing change for a mid back wound. Review of Resident #7's current FL2 dated 04/10/19 revealed diagnoses included end stage renal disease, hypertension, chronic pain, and diabetes mellitus type 2. Review of a physician's order dated 07/27/19 for Resident #7 revealed an order to cleanse mid medial back and left upper arm with wound cleaner, apply triple antibiotic ointment, and cover with a dry dressing daily until healed. Review of Resident #7's August 2019 treatment	D 276		

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administration record (TAR) revealed:
-An entry for triple antibiotic ointment cleanse mid medial back and left upper arm with wound cleanser, apply ointment and cover with dry dressing once daily until healed.
-The treatment was documented to be provided at 9:00am.
-The treatment was documented as performed from 08/01/19-08/22/19.

Observation of Resident #7 during initial tour on 08/20/19 at 11:00am revealed:
-Resident #7 was sitting on his bed picking at and scratching the skin on his left upper arm.
-Resident #7 did not have a dry dressing on his arm.

Interview with Resident #7 on 08/20/19 at 11:00am revealed:
-His arm itched "a lot."
-He applied triple antibiotic ointment on his arm to help with itching.
- "I bought it yesterday, it is easy to put on."

Observation of Resident #7 on 08/21/19 at 4:38pm revealed:
-The resident did not have a dry dressing applied to his back or his left upper arm.
-The resident had redness and open lesions on his left upper arm.
-The resident's mid medial back had a dry pink open area.

Interview with a morning shift medication aide (MA) on 08/22/19 at 1:15pm revealed:
-She worked with Resident #7 and provided care to him when she worked.
-She applied triple antibiotic ointment to Resident #7 when she worked and applied an extra-large bandage or a non-adhesive bandage with tape

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when she worked during first shift.
-Resident #7 constantly scratched his skin and the bandage fell off.
-She reapplied the bandage twice daily.
-She had not notified the physician that the resident was removing the bandage.

Interview with another morning shift MA on 08/22/19 at 1:56pm revealed:
-She worked with Resident #7 and provided care when she worked.
-She documented applying triple antibiotic ointment and administering wound care to Resident #7.
-She applied triple antibiotic ointment and applied a large band aid or non-adhesive pad to Resident #7.
-She had not observed Resident #7 removing the bandage once she placed it.

Interview with an evening shift MA on 08/22/19 at 4:29pm revealed:
-She had not observed a dry dressing applied to Resident #7's arm or back when she worked.
-Resident #7 constantly picked at his left upper arm.
-She did not realize Resident #7 had an order for wound care to his left arm and his back.

Interview with the hospice nurse on 08/22/19 at 11:50am revealed:
-Resident #7 suffered with skin lesions as related to his end stage renal disease.
-She observed Resident #7 and his back or upper left arm was not covered.
-She did not visit the resident regularly, therefore she was unsure if the bandage was applied daily.
-Resident #7 had an order for wound care to be applied daily.
-Resident #7 had some open areas that were

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reddened and should have been covered with a dressing.
-Resident #7 would be at risk for infection if his lesions were not covered.

Second interview with Resident #7 on 08/22/19 at 2:11pm revealed:
-MAs were putting a bandage on his back and left upper arm, but they stopped.
-He did not understand why the staff stopped applying the ointment and bandage.
-He applied the triple antibiotic ointment on his arm because the staff no longer applied it.
-He could not remember the last time staff applied the ointment and dry bandage to his arm and back.
-He was not able to apply the ointment to his back; however it was not itching like his arm.
-He had not mentioned to anyone that the staff no longer applied the ointment or dressing to his skin.
-The staff were not cleansing his back or left upper arm with a wound cleanser.

Interview with Resident #7's responsible party on 08/23/19 at 9:50am revealed:
-She had not observed a dry dressing on Resident #7's arm when she visited him at the facility.
-The hospice nurse called and informed her of the treatment ordered for the resident's skin.

Observation of medication and supplies available for Resident #7 on 08/21/19 at 3:58pm revealed:
-A clear zipper bag labeled triple antibiotic ointment cleanse mid medial back and left upper arm with wound cleanser, apply ointment and cover with dry dressing once daily until healed.
-There was no wound cleanser available for Resident #7.

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D 276	Continued From page 31 -There was no specific dressing available for Resident #7. Observation of the facility's treatment supply stock on 08/21/19 at 4:00pm revealed: -There was a box of adhesive extra-large band aids, non-adhesive pad with tape. -There was no wound cleanser available. Interview with the Wellness Director (WD) on 08/22/19 at 11:35am revealed: -She did not know Resident #7 had an order for wound care. -She had been out on vacation for several weeks in July 2019 when the order was written. -She was responsible for overseeing MAs. -MAs were responsible for providing care to Resident #7 and following the order for wound care as ordered by the physician. -She had not observed Resident #7 with a dry dressing on his arm or his back. -She had not provided any instructions to the MAs for how to follow wound care orders for Resident #7. -MAs were expected to follow physician orders as written and ask questions if they did not understand. Interview with the Administrator on 08/22/19 at 3:30pm revealed: -She did not know Resident #7 had an order for wound care to his back and left upper arm. -She expected staff to follow orders as written by the physician. -She expected hospice to provide supplies as required to administer the treatment orders. Attempted telephone interviews with Resident #7's primary care physician (PCP) on 08/22/19 at 11:28am, 4:35pm, and 08/23/19 at 11:02am were	D 276		

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D 276	Continued From page 32 unsuccessful.	D 276		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all residents residing in the special care unit (SCU) were provided a non-disposable place setting consisting of a knife, spoon, and fork at each meal. The findings are: Observation of the breakfast meal in the SCU dining room on 08/21/19 at 8:50am revealed: -There were 21 place settings in the dining room. -All place settings included a non-disposable fork and spoon. -There were no knives at any of the place settings. -Residents were served a breakfast meat, eggs, grits, and toast. -Residents did not ask staff for a knife. -Staff in the dining room did not offer knives to the residents.	D 287		

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D 287	Continued From page 33 -There was one resident who asked for jelly for her toast. -The resident had difficulty putting jelly on her toast with a spoon. Observation of the lunch meal in the SCU dining room on 08/22/19 at 12:41pm revealed: -There were 21 place settings in the dining room. -All place settings included a non-disposable fork and spoon. -There were no knives at any of the place settings. -Residents were served taco salad, pico de gallo, and lemon pie. -The staff in the dining room did not offer knives to the residents. Interview with a resident in the SCU on 08/21/19 at 9:30am revealed: -She did not remember receiving a knife at meals. -She did not know why she was not given a knife during meals. Interview with the SCU Coordinator on 08/22/19 at 1:00pm revealed: -Residents in the SCU had not received knives since she had been working in the facility. -She did not know why residents did not receive knives in the SCU. -She was never informed why knives were not provided to the residents. -She assumed the reason for not receiving knives was due to safety reasons. -Staff were responsible for cutting up the resident's food because all residents had a chopped meats diet order. Interview with the Dietary Manager on 08/22/19 at 12:50pm revealed:	D 287		

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D 287	Continued From page 34 -Residents in the SCU did not receive knives for safety reasons. -She did not know if residents had an order to remove knives from the place settings. -She did not know who made the decision to only provide residents with a fork and spoon with meals. Interview with the Administrator on 08/22/19 at 3:30pm revealed: -Residents in the SCU did not receive knives for safety reasons. -There was an incident that occurred "a while ago" that caused the physician to be contacted to get a physician's order to remove knives from the place setting. -She got an order as a precautionary measure to prevent injury amongst the residents. -She thought each resident had an order in their record to remove knives from the place settings. -She did not know each resident needed an individual assessment documenting the needs and preferences to remove knives from the place setting.	D 287		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by:	D 309		

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D 309	Continued From page 35 Based on observations, record reviews, and interviews, the facility failed to assure a therapeutic diet list was maintained for the guidance of dietary staff for 1 of 3 sampled residents (Resident #9) who had a physician's order for a mechanical soft diet with nectar thickened liquids. The findings are: Review of Resident #9's current FL2 dated 06/14/19 revealed diagnoses included dementia and symbolic dysfunction. Review of a subsequent physician's order dated 08/13/19 revealed Resident #9 was to be served a mechanical soft diet with no rice, nectar thickened liquids diet. Observation of the kitchen on 08/20/19 at 10:06am revealed there was no therapeutic diet list to reference for residents in the special care unit (SCU) for the guidance of food service staff. Interview with the cook on 08/20/19 at 10:06am revealed: -The diet list for the SCU was usually posted on the cork board in the kitchen. -She did not know where the diet list was located, however she knew what each resident was to be served. -The Dietary Manager (DM) was responsible for creating the dietary list and posting it on the cork board. Observation of the SCU dining room on 08/20/19 from 12:20pm to 1:08pm revealed there was no therapeutic diet list to reference for residents in the SCU for the guidance of food service staff.	D 309		

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D 309	Continued From page 36 Interview with a medication aide (MA) on 08/21/19 at 9:30am revealed: -There was not a list that could be referenced for residents ordered a therapeutic diet. -There was a picture with residents who were ordered a therapeutic diet. -There was not a picture of Resident #9 posted in the kitchen. -She knew Resident #9's diet order from memory. Interview with the SCU Coordinator on 08/21/19 at 10:03am revealed: -Diet orders were given to the DM. -The DM was responsible for updating the diet list and posting it in the kitchen. -The diet list had been posted in the dining room for staff to reference. -She did not know a diet list was not posted in the kitchen for staff to reference. -The DM was responsible for updating the diet list and making sure it was posted in the kitchen. Interview with a personal care aide (PCA) on 08/21/19 at 9:15am revealed: -She had only worked at the facility for two days as a new employee. -She did not know where the diet list was posted. -She was responsible for serving plates to the residents. -She relied on the other staff members to inform her of residents with therapeutic diets. Observation of the SCU dining room on 08/22/19 at 12:30pm revealed: -There was a current diet list posted on the side of the refrigerator. -The diet list was current as of 08/20/19. -Resident #9 was to be served a regular, chopped meats, nectar thickened liquids diet.	D 309		

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D 309	Continued From page 37 Interview with a dietary aide on 08/22/19 at 12:32pm revealed: -She worked as a dietary aide in the SCU three days per week. -She plated the food once it was received from the main kitchen. -She plated the food and gave it to the PCAs and MAs to serve the residents. -She was told verbally of the residents ordered a special diet when she was first hired. -There was a list posted in the SCU dining room on the side of the refrigerator that included current diets. Interview with the Dietary Manager (DM) on 08/21/19 at 9:20am revealed: -She was responsible for updating the diet list and making sure it was posted. -The diet list was normally posted in the main kitchen and the SCU kitchen, however it was being updated. -She picked up the wrong diet list from March 2018 when a copy of the list was requested by the surveyor. -She always made sure the diet list was posted on the side of the refrigerator in the SCU. -She expected staff to know which diet each resident was ordered. Interview with the Administrator on 08/22/19 at 3:30pm revealed: -She expected an updated therapeutic diet list to be posted in the SCU kitchen cabinet for staff to reference. -She also expected the main kitchen to have a current therapeutic diet list for the SCU so that staff would know how to prepare the food. -She expected the DM to ensure that the list was accurate and posted.	D 309		

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D 310	Continued From page 38	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 resident sampled (#9) with physician's orders for nectar thickened liquids. The findings are: Review of Resident #9's current FL-2 dated 06/14/19 revealed diagnoses included dementia and symbolic dysfunction. Review of Resident #9's diet order dated 08/13/19 revealed a mechanical soft, nectar thickened liquids diet. Observation of the lunch meal service in the Special Care Unit (SCU) dining room on 08/20/19 from 12:20pm to 1:08pm revealed: -A personal care aide (PCA) opened two small containers of liquids, poured them into two separate glasses, and served both glasses to Resident #9. -One container was labeled "iced tea-nectar consistency." -The second container was labeled "thickened water-honey consistency." -After prompting, the SCU coordinator removed	D 310		

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the honey thick water from Resident #9's place setting and replaced it with nectar thick water.

Interview with a SCU PCA on 08/20/19 at 12:58pm revealed:
-She served nectar thick tea and honey thick water to Resident #9 during the lunch meal service.
-Resident #9's beverages were kept in a drawer in the refrigerator labeled with her name.
-When she went to the drawer to get beverages for Resident #9, there was no water available.
-She asked the MA what to do and she instructed her to get water out of the box in the cabinet.
-She did not realize the water in the box was a different consistency than the tea in Resident #9's drawer.

Interview with a SCU MA on 08/21/19 at 8:16am revealed:
-She had instructed the SCU PCA to get water for Resident #9 out of the box in the cabinet.
-She knew Resident #9's diet order was for thickened liquids, but she did not know if the order was for nectar thick or honey thick liquids.
-She always served Resident #9 whatever liquid was stocked in the drawer of the refrigerator, but had never noticed what consistency she was serving.
-She did not realize the water in the cabinet was a different consistency than the tea in Resident #9's drawer.
-The dietary department was responsible for stocking the refrigerator drawer for Resident #9 with beverages of the proper consistency.

Interview with the Dietary Manager (DM) on 08/21/19 at 9:20am revealed:
-Resident #9's nectar thickened liquids were placed in a drawer in the SCU refrigerator.

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	HAL060087	A. BUILDING: _____ B. WING _____	R-C 08/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE SQUARE	5820 CAMEL ROAD CHARLOTTE, NC 28226

(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 310	Continued From page 40	D 310		

-She placed a box with Resident #9's name on top of the box in the cabinet in the SCU kitchen cabinet to restock when needed.
-There was a box of honey thickened liquids labeled with another resident's name in the cabinet that was served to Resident #9 on 08/20/19 during lunch.
-She forgot to remove the box of honey thickened liquids.
-She did not think the staff would use the honey thickened liquids as the box was labeled with another resident's name.
-She would expect the staff to read the label to prevent serving residents the incorrect consistency.

Interview with the Speech Therapist on 08/21/19 at 1:47pm revealed:
-She provided speech therapy services to Resident #9 from May 2019-July 2019.
-She recommended Resident #9 be served nectar thickened liquids because she could not tolerate thin liquids.
-Resident #9 did not have a history of choking.
-Resident #9 could not tolerate honey thickened liquids as it would be too thick to swallow.

Interview with the primary care physician (PCP) on 08/21/19 at 5:03pm revealed:
-Resident #9 was ordered a nectar thick diet to prevent aspiration and choking from occurring.
-She did not know of any past choking episodes.
-She ordered nectar thickened liquids as a result of the speech therapist's recommendations.
-She expected Resident #9 to be served nectar thickened liquids as ordered.

Interview with the Administrator on 08/22/19 at 3:30pm revealed:
-She expected residents to received therapeutic

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D 310	Continued From page 41 diets as ordered including thickened liquids. -The honey thickened liquids should have been removed from the SCU cabinet. -She expected staff to read the label on the thickened liquids prior to serving to the resident.	D 310		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to referral and follow-up to meet the acute healthcare needs of residents. The findings are: Based on observations, interviews and record reviews, the facility failed to assure referral and follow-up to meet the acute healthcare needs for 2 of 7 sampled residents related to a resident who presented with lethargy, decreased appetite and a change in her ability to ambulate independently (Resident #2), and a second resident who had blood pressures that were not	D912		

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D912	Continued From page 42 within normal limits (Resident #1). [Refer to Tag 273 10A NCAC 13F .0902 (b) Healthcare (Type A2 Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and	D935		

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D935	Continued From page 43 Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (Staff E) completed the 5, 10 or 15-hour state approved medication aide training. The findings are: Review of Staff E's medication aide (MA) personnel record revealed: -Staff E was hired on 08/22/18. -There was documentation Staff E completed the clinical skills checklist on 09/07/18. -There was documentation Staff E had passed the written medication examination on 12/06/16. -There was no documentation Staff E had completed the 5, 10, or 15-hour state approved MA training. Review of facility electronic Medication Administration Records (eMARs) for June 2019-August 2019 revealed Staff E had documented the administration of medications.	D935		

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D935	Continued From page 44 Interview with Staff E on 08/22/19 at 4:50pm revealed: -She had been employed as a MA at this facility since August 2018. -Prior to her employment at this facility, she had worked as a MA at another facility where she had completed the 15-hour state approved MA training. -She had not been asked to provide documentation of completion of the 15-hour training when she began employment at this facility. Interview with the Business Office Manager (BOM) on 08/22/19 at 5:00pm revealed: -She was responsible for ensuring the MAs completed the 15-hour state approved training. -She thought even though Staff E had passed her written medication examination after 2013, she could still accept verification of employment as a MA to exempt Staff E from the 15-hour state approved training. Telephone interview with the Administrator on 08/23/19 at 12:21 pm revealed: -Staff E worked as a MA and was responsible for administering medications to residents. -Staff E had completed the 15-hour state approved training prior to her employment at this facility, but they could not locate her completion certificate. -The BOM was responsible for ensuring staff met all qualification requirements and staff records were complete.	D935		