STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 07/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINT HILL SENIOR LIVING	10830 LAWYERS ROAD CHARLOTTE, NC 28227

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a desk review follow-up survey on 06/18/20-07/02/20 with an exit conference via telephone on 07/02/20.	{D 000}		
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 A1 VIOLATION Based on interviews and record reviews, the facility failed to assure physician notification for 1 out of 5 sampled residents who presented with altered mental status and a change in baseline function (Resident #5). The findings are: Review of Resident #'s current FL-2 dated 03/18/20 revealed diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #5's physician office note dated 02/12/20 revealed: -This was a follow-up appointment after Resident #5's last hospitalization on 01/24/20 for a COPD exacerbation. -Resident #5 had a long history of chronic COPD with recurrent exacerbation. -The respiratory assessment revealed the lungs had no abnormal findings. -Resident #5 was back to her baseline. -No changes with her O2 during the day and	D 273		

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D 273	Continued From page 1 BiPAP during the night. Review of Resident #5's progress notes revealed: -On 02/15/20 at 9:00pm, the medication aide (MA) documented, "observed resident attempting to sit up and put on Continuous Positive Airway Pressure (CPAP) machine. Resident could not sit up without falling over and did not know how the CPAP machine went on her head and face, Resident is now unable to set up CPAP on her own". -On 02/15/20 at 9:40pm, the MA documented, "observed resident is very groggy, tired and sleepy. Was unable to hold a conversation tonight. When given her pills, wasn't able to hold pill cup, dropped pills. Resident short of breath (SOB), but when asked she denies". -On 02/16/20 at 7:48am, another MA documented, "Resident was not responding when calling her name. Resident was transported by medic to (named hospital)". Review of Emergency Department (ED) notes dated 02/16/20 at 10:55am revealed: -Resident #5 was brought in by EMS with altered mental status and hypoxia (when your body does not have enough oxygen). -Per the Emergency Medical Service (EMS), Resident #5 was unresponsive and had an oxygen (O2) saturation in the 40's on room air this morning. -Upon arrival, Resident #5 was in respiratory distress with hypoxemia of 45% on room air and suspected significant hypercarbia (too much carbon dioxide (CO2) in the bloodstream). -Resident #5 was intubated by rapid sequence intubation (intubation is the process of inserting a tube in the airway to be placed on a ventilator so they can be assisted with breathing). -An Arterial Blood Gas (ABG, is a blood to	D 273		

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measure the O2 and carbon dioxide (CO2) in the blood) was obtained and confirmed respiratory failure with acute respiratory acidosis (a condition that occurs when the lungs cannot remove enough of the CO2 produced by the body) and hypercarbia.
-The vital signs were documented as follows; blood pressure 124/54, heart rate 109 (normal 60-100 beats per minute), and respiratory rate 50 (normal 12-20 breaths per minute).
-The respiratory exam documented archangelic (fast breathing), wheezing and bronchi (rattling, low pitched breath sounds).
-A portable chest x-ray was performed, and the impression was documented as the findings were compatible with congestive heart failure/pulmonary edema.
-Resident #5 was admitted to the medical intensive care unit (ICU).

Review of Resident #5's discharge summary revealed:
-Resident # was admitted to the hospital on 02/16/20 and discharged on 02/21/20.
-The hospital diagnoses included; centrilobular emphysema, severe stage 3-4 (a long term lung disease, COPD), obesity hypoventilation syndrome (is a condition in which poor breathing leads to lower oxygen and high CO2 levels in the blood), supplemental oxygen dependent, acute on chronic respiratory failure with hypoxia and hypercapnia, COPD exacerbation, acute on chronic diastolic heart failure (is a condition where the heart can not pump enough blood to serve the body's needs), and hypertension.

Telephone interview with Resident #5's physician on 06/30/20 at 12:20pm revealed:
-Resident #5 was seen in the office on 02/12/20 for a follow-up visit after a 4 day hospitalization

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during 01/25/20-01/28/20 for respiratory failure.
-Resident #5 was in "horrific" physical condition, continued to smoke, severe COPD with frequent exacerbations, on oxygen at 4 liters during the day and a non-invasive ventilator (NIV) to be used at night.
-He considered Resident #5's baseline to be "terrible at best" meaning no breathing difficulty at the time.
-He ordered the NIV because Resident #5's oxygen (O2) levels would drop and her carbon dioxide (CO2) levels would rise if she did not use the NIV at night.
-During the day Resident #5 was on 4 liters of O2 via nasal cannula.
-If Resident #5's O2 levels dropped and her CO2 levels increased then that would cause a COPD exacerbation which would result in another hospitalization.
-With Resident #5's COPD, if her O2 levels dropped below 80% (out of 100), she would become short of breath, confused and drowsy.
-Resident #5's O2 levels should stay above 80% to keep from having a COPD exacerbation.
-If Resident #5 was not wearing her O2 during the day as ordered, or not wearing her NIV at night as ordered then her CO2 levels would increase because the O2 levels would not be sufficient, then Resident #5 would become short of breath followed by confusion which could lead to acute respiratory failure which could then lead to death.
-The next communication he documented in his record was dated 02/17/20 from the facility staff notifying him Resident #5 was in the Hospital in Intensive Care Unit (ICU).
-There was no other communication in his records regarding Resident #5 on 02/17/20.
-He expected the staff to notify him of Resident #5's altered mental status because he considered that a significant change in Resident #5's

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baseline.
-An altered mental status change in Resident #5 could be a result of her O2 decreasing and her CO2 increasing which would require immediate emergency attention.
-"The faster you get help the better off" she would be.
-He considered an altered mental status a significant change in Resident #5's condition and he expected the facility staff to notify 911 immediately, at the very least call him and inform him of Resident #5's condition.
-If the staff had notified him then he would have had the staff to call 911 immediately.
-That was a big change with Resident #5 and the staff did not need approval to send her to the hospital with that significant change, not let Resident #5 be that was all night.

Telephone interview with a MA on 06/30/20 at 1:52pm revealed:
-She worked the 3:00pm to 11:00pm shift and was the MA for Resident #5 on 02/15/20.
-She was trained on how to apply Resident #5's NIV at night.
-Resident #5 usually applied the NIV herself after she was finished watching tv.
-She recalled a night she documented in the progress notes in February 2020, not sure of the date, Resident #5 was attempting to put on the NIV mask around 9:00pm, Resident #5 was "not with it and "confused", kept falling over, short of breath and could not hold onto her medications, she kept dropping medication cup.
-She tried to help Resident #5 put the NIV mask on but was unsuccessful because Resident #5 "would keep removing it".
-She left the facility around 11:00pm and did not know if Resident #5 had her NIV on.
-Based on the progress notes, she was able to

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recall Resident #5 was groggy as if "she had just woken up after a deep sleep", "abruptly" but still tired and sleepy like "wanting to go back to sleep", "eyes kept closing" and trying to get her "wit's about her".
-She was not sure if Resident #5 refused to go to the hospital or would go in the morning.
-She did not notify the physician of the change in Resident #5's capability of putting on the mask, or that Resident #5 could not sit up without falling over or Resident #5 being "groggy", "tired and sleepy", and "eyes kept closing".
-Another MA documented on the electronic Medication Admiration Record (eMAR) Resident #5's NIV machine was turned on and the mask was on.
-She notified the Director of Resident Care (DRC) that night (02/15/20) by using the facility Crew Application on the cell phones but did not receive a reply.
-She left the facility after her shift was over around 11:00pm.
-A verbal report was given to the on-coming shift MA but she could not recall who that was.
-She did not check on Resident #5 again after 9:00pm.
-The policy for a change in mental status was to notify the DRC and follow her instructions. If the DRC did not respond, then she was to call the Memory Care Coordinator (MCC) or the Administrator.
-She did not call the MCC or the Administrator.
-The DRC at the time only allowed the MAs to contact the physician if the DRC gave them permission.
-The MAs could call 911 in an emergency.
-An altered mental status was considered an emergency and Resident #5 was not "acting right" and confused about how to put on her mask.
-She did not think that Resident #5's actions were

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considered altered mental status, but it was a change in Resident #5's condition.
-Her example of altered mental status was confusion and unconsciousness.
-She was "surprised" Resident #5 was sent out to the hospital the next morning.

Telephone interview with the Administrator on 06/30/20 at 2:56pm revealed:
-The MAs were to report any changes in the resident's condition to the DRC.
-If the DRC did not answer then the MAs were to notify the MCC and/or her.
-In February 2020, there was another DRC in the position and that DRC "demanded" all MAs report all changes in the residents to the DRC and the DRC would contact the physician. There were to be no calls made to the physician except by the DRC.
-The MAs could call 911 for altered mental status, chest pain, falls with head injuries, stroke, a resident unconsciousness, and if the resident was not able to make a choice, such as confusion, then the MAs made it for them.
-She expected the MAs to notify the DRC and if there was no answer from the DRC then notify the MCC and her.
-A MA was not to let the issue go with out a reply from any one of the three staff above.
-She considered Resident #5 "falling over" more than once and confusion a change in mental status that warranted a call to 911.
-She was not aware of Resident #5 change in mental status until the next day (02/16/20) when Resident #5 was sent out to the hospital.

Telephone interview with the current DRC on 06/30/20 at 3:40pm revealed:
-She was the MCC when Resident #5 was sent to the hospital for altered mental status and

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D 273	Continued From page 7 unresponsive. -The policy for the MAs during that time was to call the DRC and if no reply from the DRC, to call her, the MCC at the time or the Administrator. -The MA did not get a hold of the DRC, and did not notify her, Administrator or the physician that night, and Resident #5 was found unresponsive in her room the next morning by a first shift MA. -911 was called by the MA immediately. -Resident #5 was transported to the hospital. _____ The facility failed to assure physician notification for a resident with an extensive history of chronic obstructive pulmonary disease and repeat hospitalizations who was presenting with shortness of breath, confusion, inability to sit upright, hold a medication cup or apply her non-invasive ventilator and allowed to go to sleep. The resident was found unresponsive the following morning with an oxygen level in the 40's. The resident required intubation and a ventilator with a 5 day hospitalization. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 June 30, 2020. CORRECTION DATE FOR THE UNABATED TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 1, 2020.	D 273		
{D914}	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	{D914}		

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{D914}	Continued From page 8 This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents were free of neglect, abuse and exploitation related to health care. The findings are: Based on interviews and record reviews, the facility failed to assure physician notification for 1 out of 5 sampled residents who presented with altered mental status and a change in baseline function (Resident #5). [Refer to tag 0273, 10 A NCAC 13F .0902(b) Health Care, Type A1 Violation].	{D914}		