Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
)
		HAL060087	B. WING		08/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHARLO	TE SQUARE	5820 CAMI	EL ROAD			
CHARLO	TE SQUARE	CHARLOT	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	survey onsite on 08/0 review survey on 08/0	Department of Social complaint investigation 3/20 & 08/13/20 with a desk				
D 188	10A NCAC 13F .0604 Other Staffing	I(e) Personal Care And	D 188			
	Staffing (e) Homes with capa shall comply with the home is staffing to ce below 21 residents, the ahome with a census (1) The home shall his the needs of the residuty hours on each 8 be at least: (A) First shift (morning for facilities with a census determined in the needs of the residents; and 16 hou additional hours of aid 10 or fewer residents or capacity of 40 or more capacity of additional hours additional 10 or fewer census or capacity of staffing chart, see Ru (C) Third shift (evening per 30 or fewer residents)	ave staff on duty to meet dents. The daily total of aide chour shift shall at all times ag) - 16 hours of aide duty assus or capacity of 21 to 40 ars of aide duty plus four de duty for every additional for facilities with a census are residents. (For staffing of this Subchapter.) ernoon) - 16 hours of aide a census or capacity of 21 lie hours of aide duty plus				

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	, , , , , , , , , , , , , , , , , , ,			С		
		HAL060087	B. WING		08/17/2020	0
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	FE. ZIP CODE	•	
			MEL ROAD			
CHARLO	TE SQUARE	CHARLO	TTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COM	X5) IPLETE ATE
D 188	meet the needs of the residents equal to the by Medicaid. As used "heavy care resident" residing in an adult ca "heavy care" by Medi is receiving enhanced (E) The Department if it determines the ne	oter.) have additional aide duty to e facility's heavy care e amount of time reimbursed d in this Rule, the term, , means an individual are home who is defined as caid and for which the facility	D 188			
	facility failed to ensur- were always present residents residing in t for 22 of 54 shifts san 07/10/20 and 08/13/2 The findings are: Review of NCDHHS I Recommendations do pandemic revealed:	ews and interviews, the e the minimum number staff to meet the needs of he Assisted Living (AL) unit npled for 18 days between 0. Emergency Staffing uring the COVID-19				
	unable to work until the returning to work. This shortages at a time we to control the outbreat-Facilities should preg	e for COVID-19 will be ney meet the criteria for s can cause sudden staffing then extra work is required k. pare for the possibility of d have a concrete plan with				

Division of Health Service Regulation

STATE FORM 6899 2SZ411 If continuation sheet 2 of 118

DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIL	LILD
					c	;
		HAL060087	B. WING		08/1	7/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE COLLADE	5820 CAME	L ROAD			
CHARLUI	TE SQUARE	CHARLOT	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 188	Continued From page	2	D 188			
D 188	specific steps to take staff. -The following options emergency staffing: -Allowing caregivers asymptomatic to staff for positive residents PPE)Contacting temporar-Contacting other sist staffing supportContacting local host supportIf all these options ha additional staffing is separtment can requestateEmergency staffing reseveral days to fillFacilities should begistaff as soon as staff waiting for test results emergency staffing renecessary. Staffing and emergen requested on 08/04/2 provided. Review of the facility's Division of Health Set the facility was license (AL) with a capacity of the staffing renecessary.	if they do need additional s should be considered for that are positive but areas dedicated to caring (while wearing appropriate y staffing agencies. er agencies for temporary pitals for temporary staffing ave been exhausted and till needed, your local health est emergency staff from the equests typically take in searching for additional are tested rather than s to come back, so these	D 188			
	07/10/20 revealed:	nt Bed List Report dated of 75 residents in the AL				

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-There should have been a total of 32 aide hours

STATE FORM 8899 2SZ411 If continuation sheet 3 of 118

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			P WING		С
		HAL060087	B. WING		08/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CHARLOTTE SQUARE 5820 CAM					
		CHARLO	TTE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 188	Continued From page	e 3	D 188		
	on first shiftThere should have b on third shift.	een a total of 24 aide hours			
	Review of the Employee Time Detail dated 07/10/20 revealed: -There were 24.72 staff hours provided on the first shift, a shortage of 7.28 hoursThere were 15.75 staff hours provide on the third				
	shift, a shortage of 8.25 hours. Review of the Resident Bed List Report dated 07/11/20 revealed: -There was a census of 75 residents in the AL unit.				
	on first shiftThere should have b on second shiftThere should have b	een a total of 32 aide hours een a total of 32 aide hours een a total of 24 aide hours			
	shift, a shortage of 3.3. -There were 22.80 sta second shift, a shorta	aff hours provide on the first 24 hours. aff hours provided on the ge of 9.17 hours. aff hours provided on the			
	07/12/20 revealed: -There was a census unitThere should have b on first shift.	of 75 residents in the AL een a total of 32 aide hours een a total of 32 aide hours			

Division of Health Service Regulation

-There should have been a total of 24 aide hours

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DIVISION	n Health Service Negu	ialion	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					_	, J
			B. WING		C	
		HAL060087	B. WING		08/1	7/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
		5820 CA	MEL ROAD			
CHARLOTTE SQUARE		TTE, NC 28226				
	OLIMANA DV OT			DDOV/DEDIO DI ANI OF CODDECTIO	N. I	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF		DATE
				DEFICIENCY)		
D 188	Cantinuad Francisco	- 4	D 188			
ו 100	Continued From page	2 4	D 100			
	on third shift.					
	Review of the Employ	yee Time Detail dated				
	07/12/20 revealed:					
	-There were 25.01 sta	aff hours provide on the first				
	shift, a shortage of 6.9	99 hours.				
	-There were 22.80 sta	aff hours provided on the				
	second shift, a shorta	ge of 9.20 hours.				
	-There were 15.59 sta	aff hours provided on the				
	third shift, a shortage of 8.41 hours.					
	_					
	Review of the Reside	nt Bed List Report dated				
	08/02/20 revealed:					
	-There was a census	of 72 residents in the AL				
	unit.					
	-There should have b	een a total of 32 aide hours				
	on first shift.					
	-There should have b	een a total of 32 aide hours				
	on second shift.					
	-There should have b	een a total of 24 aide hours				
	on third shift.					
	Review of the Employ	yee Time Detail dated				
	08/02/20 revealed:					
	-There were 28.98 sta	aff hours provided for first				
	shift, a shortage of 3.	02 hours.				
	-There were 14.63 sta	aff hours provided for				
	second shift, a shorta	ige of 17.37 hours.				
	-There were 15.38 sta	aff hours provided on the				
	third shift, a shortage					
		nt Bed List Report dated				
	08/07/20 revealed:					
		of 71 residents in the AL				
	unit.					
	-There should have b	een a total of 32 aide hours				
	on second shift.					
	-There should have b	een a total of 24 aide hours				
	on third shift.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		
					c
		HAL060087	B. WING		08/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE	
CHARLOT	TE SQUARE		MEL ROAD		
			TTE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 188	Continued From page	e 5	D 188		
	second shift, a shorta -There were 15.00 sta shift, a shortage of 9	aff hours provided on the ge of 1.94 hours. aff hours provide on the third hours.			
	Review of the Resident Bed List Report dated 08/08/20 revealed: -There was a census of 71 residents in the AL unit. -There should have been a total of 32 aide hours on first shift.				
	on first shift. -There should have been a total of 32 aide hours on second shift. -There should have been a total of 24 aide hours on third shift.				
	Review of the Employee Time Detail dated 08/08/20 revealed: -There were 29.64 staff hours provided on the first shift, a shortage of 2.36 hoursThere were 16.41 staff hours provided on the second shift, a shortage of 15.59 hoursThere were 15.00 staff hours provide on the third shift, a shortage of 9 hours.				
	Review of the Resident Bed List Report dated 08/12/20 revealed: -There was a census of 70 residents in the AL unitThere should have been a total of 28 aide hours on first shiftThere should have been a total of 28 aide hours on second shiftThere should have been a total of 24 aide hours on third shift. Review of the Employee Time Detail dated 08/12/20 revealed:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		
		HAL060087	B. WING		C 08/17/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CHARLOTTE SQUARE 5820 CAM			IEL ROAD		
		CHARLO	TE, NC 28226		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 188	Continued From page	e 6	D 188		
	first shift, a shortage of -There were 23.61 states second shift, a shorta	aff hours provided on the ge of 4.39 hours. aff hours provided on the			
	08/13/20 revealed: -There was a census unitThere should have b on first shift.	of 71 residents in the AL een a total of 32 aide hours			
	on second shift.	een a total of 32 aide hours een a total of 24 aide hours			
	Review of the Employee Time Detail dated 08/13/20 revealed: -There were 23.43 staff hours provide on the first shift, a shortage of 7.57 hours.				
	second shift, a shorta	aff hours provided on the			
	08/06/2020 at 2:42pm -She was the only ass the facility from 11:00 07/10/20 and 08/13/2 -She was responsible medication to residen -She was responsible or accidents involving -The assisted living u one or two PCA's on -In July 2020, there w	signed MA on third shift for pm until 7:00am between 0. e for administering PRN ts on third shift. e for responding to incidents presidents on third shift. nit was usually staffed with			

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DIVISION	i Health Service Regu	iauon i			T	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	l
						l
			B. WING		C	
		HAL060087	D: WING		08/17/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, STA	TE, ZIP CODE		
		5820 CAI	MEL ROAD			
CHARLOT	TE SQUARE		TTE, NC 28226			
			1112, NO 20220	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		
1/10		,	17.0	DEFICIENCY)		
			+			
D 188	Continued From page	e 7	D 188			
	aggisted living unit					
	assisted living unit.	have shift assess days was				
		-hour shift, seven days per				
	week on third shift at					
	•	shift hours on the assisted				
	_	ulative one-hour total on the				
	SCU unit during third					
		RN medications to all the				
	residents on the SCU	, but she couldn't recall				
	which residents she gave their PRN medication that had tested positive for COVID-19.					
	-She was familiar with	n some assisted living unit				
	residents that require	d scheduled medication				
	administration during					
	•	utilizing healthcare agency				
		nately June 2020 due to				
	insufficient facility sta	-				
	-	at on numerous occasions				
		e were only three staff				
	•	-				
		including one MA and two				
	PCA's between the as	ssisted living unit and SCU.				
	Confidential talenham	a imbamaianu mibla a NAA				
	Confidential telephon	e interview with a MA				
	revealed:					
	•	understaffed since May				
	2020.					
		lity staffed two MA's and				
		the assisted living unit.				
		cility occasionally staffed one				
	MA and one care aide	e for the assisted living unit				
	in July 2020.					
	-She did not know wh	o was responsible for				
	scheduling staff.					
	_	ı utilizing a healthcare				
		cancies in the schedule up				
	until approximately M					
		rator had instructed staff to				
		nation staff shared with				
		ing and other activities				
	occurring in the facilit	_				
	occurring in the facilit	у.	1			

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060087	B. WING		08/1	; 7/2020
NAME OF D	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIR CODE	1 00/1	172020
NAME OF F	ROVIDER OR SUFFLIER	5820 CAME		TE, ZIF CODE		
CHARLOTTE SQUARE CHARLOT		ΓE, NC 28226				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 188	Continued From page	e 8	D 188			
	Telephone interview on 08/14/2020 at 3:00 -She worked as a PC on first shift and occa -In July 2020 and Aug and another PCA wor shift MA, but usually t workingShe did not know hor needed on first shiftThere were a lot of re personal care assistat difficult to perform per only two PCAsThe first shift MA wor care if they were not t and doing other tasks resident recordsIn July 2020 and Aug worked as a PCA on a -There were a few oc August 2020, when s working on third shift Telephone interview w 08/11/2020 at 11:49ar -She was responsible living unit staff in July -She scheduled staff schedules and tried to available facility staffThe schedule was sh Wellness Nurse (HWI reviewShe was not respons healthcare agency sta	with a first & third shift PCA Opm revealed: A on the assisted living unit sionally on third shift. Gust 2020, on occasion, she ked on first shift with a first there were three PCAs w may PCAs the facility esidents that required nce on first shift, and it was resonal care assistance with fould only assist with resident busy passing medications as such as writing notes in gust 2020, she occasionally third shift. Casions in July 2020 and the was the only PCA with a third shift MA. with a lead MA on merevealed: for scheduling assisted 2020. according to pre-set staff of fill schedule vacancies with mared with the Health & N) and the Administrator for				

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Telephone interview with the HWN on 08/14/2020

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING				
		HAL060087	B. WING		08/17	/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
CHARLOTTE SQUARE 5820 CAN			IEL ROAD				
CHARLO	TE SQUARE	CHARLO	TTE, NC 28226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 188	Continued From page	9	D 188				
	at 1:07pm revealed: -She was responsible staff met the healthca of residentsShe was not responsible prior to August 2020She expected the thin on the assisted living which was 11:00pm ure she expected the thin check-in with the SCU respond to incidents of PRN medications to the transfer agency in the vacancies but, around unable to fulfill all the facilityThe facility attempted	of for assuring MAs and PCA are and personal care needs stible for scheduling staff and shift MA to work primarily unit during the third shift, and 7:00am. To shift MA to occasionally J PCAs during third shift and for accidents and administer the AL and SCU residents. It to utilize a healthcare past to fill schedule May 2020, the agency was schedule vacancies for the did to utilized facility staff all schedule vacancies to					
	Telephone interview of 8/17/2020 at 3:19pm - She was aware of the requirements for the according to the daily - She had assigned a for scheduling assisted 2020. -The lead MA shared schedule with her and address shift vacancies - She was aware the amaintained approximate July and August 2020. -She expected the thing the assisted living uniterview of the second se	with the Administrator on revealed: e facility staffing assisted living unit and SCU census. lead MA to be responsible and living unit staff in July the assisted living unit staff in the HWN for review and to less. essisted living unit ately 75 residents per day in living the shift MA to float between					

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assisted living unit for a total of four hours per

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060087	B. WING		08/1	; 7/2020
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	1 00/1	112020
		5820 CAME		12, 211 0002		
CHARLO	TE SQUARE	CHARLOT	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 188	Continued From page	e 10	D 188			
	shiftShe expected the as staffed with two PCA' -She was not aware to been staffed with one numerous occasions 2020She expected staff, in staff schedules when called-out, was placed vacancy was filled with -Occasionally schedule crossed out on shift sound a replacement stavacant shift schedule available to cover the -When staff called out HWN was expected to find a replacement or themselvesOn 08/08/20 the staff someone on the man not have enough staff someone on the man not have enough staff she did not routinely she was not onsite to she expected the staff when staffing issues of Attempted telephone staffing agency manal and 08/17/20 at 11:05. Attempted telephone staffing agency human 11:15am were unsuccessive.	sisted living unit to be s and one MA on third shift. he assisted living unit had PCA and one MA on in July 2020 and August ncluding herself, to update a scheduled staff member d on leave, or a schedule th a healthcare agency staff. led staff names were chedules due to calling out aff name was added to the if a replacement staff was vacant shift. It sick the lead MA and/or the be notified, so they could take the assignment for duty failed to notify agement team that they did if to administer medications. Contact the facility when check for adequate staffing, if to contact management occurred. Interviews with contract ger on 08/14/20 at 12:05pm fam were unsuccessful.				

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Refer to Tag 358, 10A NCAC 13F .1004(a)

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		UAL 000007	B. WING		C	
NAME OF D	ROVIDER OR SUPPLIER	HAL060087	RESS, CITY, STA	TE ZIR CODE	08/17/2020	
		5820 CAME		TE, ZII GODE		
CHARLOTTE SQUARE CHARLOT		TE, 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 188	Continued From page	e 11	D 188			
	Medication Administra	ation.				
	facility failed to ensure were always present residents residing in the for 22 of 54 shifts san 07/10/20 and 08/13/2 resulted in a lack of a supervise and adminimental to the heat the residents and continuous for this violation. THE CORRECTION I	the Assisted Living (AL) unit inpled for 18 days between 0. The facility's failure dequate staff on the unit to ster medications was alth, welfare, and safety of institutes a Type B Violation.				
D 310	10A NCAC 13F .0904 Service	(e)(4) Nutrition and Food	D 310			
	(e) Therapeutic Diets(4) All therapeutic die supplements and thic	Nutrition and Food Service in Adult Care Homes: ets, including nutritional kened liquids, shall be the resident's physician.				
	review the facility failed diet was served as or	as evidenced by: ns, interviews and record ed to ensure a therapeutic dered for 1 of 5 sampled 3) with physician's orders for				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					c	
		HAL060087	B. WING		08/17/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE SQUARE	5820 CAM				
			TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 310	Continued From page	e 12	D 310			
	a nutritional suppleme	ent.				
	The findings are:					
	Review of Resident # 11/06/19 revealed dia Alzheimer's dementia pre-diabetes.					
	a. Review of Resident #3's signed Physician Order Report dated 04/20/20 revealed there was an order for a nutritional supplement, used to treat protein deficiency, once daily.					
	medication administra 06/01/20 through 06/3 -There was a comput	er-generated entry for a t to be administered daily at onal supplement was nistered 30 out of 30				
	07/01/20 through 07/3 -There was a comput	er-generated entry for a t to be administered daily at onal supplement was				
	08/01/20 through 08/ -There was a comput	er-generated entry for a t to be administered daily at onal supplement was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		EIED
					c	
		HAL060087	B. WING		08/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CHARLO	TE SQUARE	5820 CAM	EL ROAD			
CHARLO	TE SQUARE	CHARLOT	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETE DATE
D 310	Continued From page	: 13	D 310			
	opportunities.					
	08/13/20 at 9:00am re -There was a case of the top of Resident #3 -The case contained t vanilla nutritional sup -There were nine rem -There was a case of box labeled with Resi room cabinetThe case contained t of vanilla nutritional su -There were seventee caseThirty of the fifty-six a	nutritional supplements on B's closet. Chirty-two 8-ounce cartons of colement. Caining cartons in the case. Chirty-two 8-ounce cartons of colement. Caining cartons in the dining Colement #3's name in the dining Colement. Cartons cartons Colement. Cartons in the Cavailable nutritional Colement Properties Cartons in the Cavailable nutritional Colement Properties Cartons in the Cavailable nutritional Colement Properties Cartons In the Cavailable nutritional Cartons In the 2 cases				
	Attorney (POA) on 08 -She provided the nut Resident #3She provided 1 case on 02/13/20.	with Resident #3's Power of /13/20 at 10:20am revealed: ritional supplement for of 32 protein supplements				
		or" policy, she kept track of ment stock when she visited				
	Resident #3Since the facility rest the previous Special 0 contacted her when th were lowShe ordered a new of -No one from the facil regarding Resident #3 supply from 02/13/20 -She contacted the fa	ricted non-essential visitors, Care Coordinator (SCC) ne nutritional supplements ase at that time. ity had contacted her b's nutritional supplement				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL060087	B. WING		08	C / 17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	, ,	
			MEL ROAD			
CHARLO	TE SQUARE	CHARLO	OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 310	from 02/25/20 through -She sent the nutrition the facility since there -Resident #3 did not a the nutritional suppler for "protein deficiency -Resident #3 was cog unable to feed herself -Resident #3 was dep her needs. Interview with a medic 08/03/20 at 2:15pm re -Nutritional suppleme room cabinetShe thought Resider provided the suppleme -The MAs were respondocumenting nutrition eMARsShe administered Re supplement when she SCU. Telephone interview w 08/10/20 at 1:04pm re -She worked primarily -The nutritional supple were in her bedroom -She did not know hor re-suppliedShe administered Re supplements when she SCU.	and case of 24 protein 5/20. Applements were provided on 08/13/20. Inal supplements directly to e was a "No Visitor" policy. Always eat her meals and ment had been prescribed ". Intively impaired and was for make her needs known. Interest on the staff for all cation aide (MA) on evealed: Ints were kept in the dining on the staff for serving and hal supplements on the exident #3's nutritional e worked as the MA in the cation aide: In the SCU as a MA. In the SCU as a MA.	D 310			
	at 11:17am revealed:	viui a uiiiu iviA OII UO/ 12/2U				

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A. BUILDING:	С
HAL060087 B. WING	8/17/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
CHARLOTTE SQUARE 5820 CAMEL ROAD	
CHARLOTTE, NC 28226	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY SPLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310 Continued From page 15 D 310	
-Resident #3 required staff assistance with eatingResident #3 has an order for a nutritional supplementShe administered the nutritional supplement as ordered, once dailyShe would inform the Health & Wellness Nurse (HWN) if the supply ran lowShe did not know who provided Resident #3's nutritional supplement. Interview with the HWN on 08/13/20 at 2:30pm revealed: -The MAs administered nutritional supplements as ordered to the residentsShe knew Resident #3 was on a nutritional supplement for protein deficiencyShe knew the POA provided the nutritional supplements and the MAs were to administer 1 carton dailyThe previous SCC would have been responsible for notifying the POA if Resident #3's nutritional supplement supply was running lowShe knew the amount provided by the POA did not cover the past 6 monthsThere was another resident who was also on a nutritional supplements in the dining room cabinetsThe facility had been providing Resident #3 with the nutritional supplements the second resident left behindShe was not sure how many nutritional supplements were left behind or what type of nutritional supplement sure how many nutritional supplements were left behind or what type of nutritional supplement the supply had been completedShe was not sure when the supply of the second	

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completed.

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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		HAL060087	B. WING		08/17/2020
			•		·
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
011451.07	TE 00114 DE	5820 CAI	MEL ROAD		
CHARLOI	TE SQUARE	CHARLO	TTE, NC 28226		
	CUMMADV CT			DDOV/DEDIC DI ANI OF CODDECTION	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	\ -/
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
		,		DEFICIENCY)	
			+		
D 310	Continued From page	e 16	D 310		
		with the hospice registered			
	nurse (RN) on 08/17/2	20 at 2:32pm revealed:			
	-Resident #3 was a h	ospice client in 2019 and			
		services in February 2020.			
	•	ritional supplements was			
		Resident #3's first admission			
	for protein calorie def				
	-Hospice resumed ca				
	07/22/2020 and conti	nued the previous orders			
	that were already in p	olace.			
	-The order for Reside	ent #3's nutritional			
	supplement, once dai	ily, had continued after			
	discharge from hospi				
		impairment, Resident #3			
	had forgotten how to				
	•				
	•	rab a spoon or fork but did			
	not know how to use				
	-	to the staff the necessity to			
	feed Resident #3 at n	neal time.			
	-She assisted Reside	nt #3 at meal time when the			
	food tray was placed	in front of her and Resident			
	#3 was not eating.				
	-Based on the facility'	's monthly weight			
	-	nt #3 had lost 4 pounds (lbs.)			
	*	when she was discharged			
	from hospice services				
		cumented as 100 lbs in			
	_	as documented as 96 lbs in			
	July 2020.				
	Telephone interview v	with the Administrator on			
	08/17/20 at 3:53pm re	evealed:			
		onsible for administering			
		he eMAR for the residents.			
		nts for the residents were			
	kept in the SCU.	THE TOTAL TOTAL THE WEIG			
		maile la fan amanusis es tile e			
		nsible for ensuring the			
	nutritional supplemen	its were available for			

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administration.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:	
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		HAL060087	B. WING		08/17/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
		5820 CAM	EL ROAD		
CHARLOT	TE SQUARE	CHARLOT	TE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 310	Continued From page	= 17	D 310		
5 0.0	-The SCC position wa -The HWN was responded in the HWN was responded in the Factor of medications and places of medicatio	as currently not filled. Onsible for the administration hysician orders. POA provided the nutritional dent #3. esident #3 had not been hal supplements daily. As to administer the orders ery resident. Olements were not available he MAs should have			
D 338	10A NCAC 13F .0909	Resident Rights	D 338		
	all residents guarante Declaration of Reside and may be exercised	chall assure that the rights of eed under G.S. 131D-21, ents' Rights, are maintained d without hindrance.			
	This Rule is not met TYPE A1 VIOLATION	-			
	interviews, the facility recommendations and the Centers for Diseat Carolina Department Services (NC DHHS) local health department and maintained to proceed the company of	d guidance established by see Control (CDC), the North of Health and Human and directives from the ent (LHD) were implemented ovide protection of the global coronavirus c as related to screening and residents, use of personal (PPE) by staff and			

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the risk of transmission and infection.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
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	HAL060087 B. WING			08/17/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE	
		5820 CAM	EL ROAD		
CHARLOT	TE SQUARE	CHARLOT	TE, NC 28226		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 338	Continued From page	e 18	D 338		
	The findings are:				
	Review of the CDC gr	uidelines for the prevention			
		onavirus in long-term care			
	(LTC) facilities revealed				
		vays wear a face mask in			
	the facility.	act he were under the page			
	or mouth.	not be worn under the nose			
		ould be implemented among			
	the residents.	sala so implemented among			
		fied in the facility, restrict all			
	residents to their roor				
		n or suspected COVID-19			
		sing recommended PPE			
		on, gloves, gown, and a N95			
	respirator face mask.	ho used if a NOE mask is			
	not available.	be used if a N95 mask is			
	-Ensure that environn				
		es are followed consistently			
	and correctly.	d disinfection procedures			
	•	and water to pre-clean			
	· · · · · · · · · · · · · · · · · · ·	ying an Environmental			
	Protection Agency (El				
	hospital-grade disinfe	ctant to frequently touched			
		r appropriate contact times			
	as indicated on the pr	•			
	appropriate for corona	avirus in healthcare settings.			
	Review of the addition	nal CDC guidelines for			
		CU) that should be used to			
		OVID-19 guidance in LTC			
	facilities revealed:	-			
	•	ging to restrict residents to			
		potential risks and benefits			
		ut of the memory care unit			
	to a designated COVI	D-19 care unit.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		HAL060087	B. WING		08/17/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE SQUARE	5820 CAM				
		CHARLOT	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 338	Continued From page	e 19	D 338			
		structured activities, which				
	-	the resident's room or be				
		ed times throughout the day				
		tancing at least 6 feet apart. or residents to continue to be				
		nnel walking with individual				
	residents around the	<u> </u>				
		esidents or space residents				
		s much as feasible when in				
		gently redirect residents and are near other residents				
	or personnel.	and are near other residents				
	=	en-touched surfaces in the				
	memory care unit, es	pecially in hallways and				
		e residents and staff spend a				
	lot of time.					
	-Ensure that environn	nental cleaning and es are followed consistently				
	and correctly.	•				
	_	d disinfection procedures				
		and water to pre-clean ying an EPA-registered,				
		ectant to frequently touched				
	. 0	or appropriate contact times				
	as indicated on the pr					
		D-19 in healthcare settings,				
	•	nt-care areas in which				
	aerosoi generating pr	ocedures are performed.				
	Review of the NCDH	HS for prevention and				
	spread of the corona	· · · · · · · · · · · · · · · · · · ·				
	revealed:					
		wear appropriate PPE when				
		th undiagnosed respiratory				
	•	d wear a face mask while in				
	the facility.	1 100/75 10				
		n or suspected COVID-19 ced in a private room with				

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their own bathroom.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060087	B. WING		08	C 3/ 17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
			MEL ROAD			
CHARLO	TTE SQUARE	CHARLO	OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 338	residents who test possible cohorted in a desfor by a consistent greater. Review of the facility policy revealed the prinfection prevention (application of putting PPE, appropriate clehigh touch surfaces, alternative measures residents.	nts and asymptomatic positive for COVID-19 should ignated location and cared roup of designated facility. Is 2020 infection control policy contained no COVID-19 polan to address donning gon) and doffing (removal of) aning and disinfecting of social distancing, and a for the management of SCU uidelines for prevention and	D 338			
	spread of the COVID June 2020 revealed: -All LTCFs should be testing capacity to quany cases of COVID -In addition to on-goi monitoring of staff ar should develop a pla staffFacilities with identifi to perform testing on -When one or more of identified the facility testing of all asymptor residents and staff af of at least 14 days si resultAfter 14 days passe symptom and monitor residentsComplete LHD COV report staff and residents	e prepared with adequate sickly detect and respond to 1-19 in the facility. In graph symptom screening and addresidents the facility in for weekly testing of all sied cases of COVID-19 was all residents and staff. Cases of COVID-19 was was to continue repeat viral signature previously negative opproximately every 3-7 days ince the most recent positive indicate and continue screening				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _	A. BUILDING:		EIED
			D WING			
		HAL060087	B. WING		08/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE SQUARE	5820 CAM	EL ROAD			
		CHARLOT	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	e 21	D 338			
	emergency room (ER hospitalizations with le), and date of				
	_	ided by the Administrator				
		s had tested positive for				
		positive on 07/10/20 and 4/20 and returned to the				
		-19 screening logs for staff on 08/13/20 at 9:30am				
	PCAs currently working	•				
		ening logs dated 08/06/20 to atures documented with				
	•	ranging from "87.6 to 97.1".				
		nd temperatures taken.				
	Review of the LHD Er Request for Service F revealed:	nvironmental Health Report dated 07/06/20				
	reached out to facilitie	mental Health Specialist es experiencing health				
	0 0	dance on approved cleaning				
	products, usage and t	frequency. nental Health Specialist				
		versation on 07/06/20 with				
	the Health & Wellness					
	facility.					
		he facility was using orange				
	top bleach germicidal	disposable wipes, a nd green top sani-cloth				
		e wipes for cleaning and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
HAL060087		B. WING		C 08/17/2020	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE. ZIP CODE	1 00:11:2020
			IEL ROAD		
CHARLO	TE SQUARE	CHARLO	TTE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 338	Continued From page	22	D 338		
	on the EPA approved NThe HWN also repor	t stated the green top disposable wipes were not list to kill COVID using List ted the staff were taking gs of the residents 3 times a			
	cleaner, bactericidal, fungicidal disinfectant -The disinfectant kille minutes after 2 ounce	ne SCU on 08/03/20 a hospital grade one-step viricidal, mildewcidal,			
	move-out roster dated -There were 15 reside -One of the residents -There were five residents positive for COVID-19 -There were five emp	ents residing in the SCU. was in the hospital. lents identified as testing). ty rooms one was last and the other four empty			
	the SCU residents rev -Resident temperature each shift.	perature Log Reports" for vealed: es were to be completed on ry was documented on			
	-A medication aide (M	:30pm-2:00pm revealed:			

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AND PLAN OF CORRECTION IE	DENTIFICATION NUMBER:	A BUILDING:		(X3) DATE SURVEY COMPLETED	
		, 50.25o. <u> </u>			
		B. WING		С	
	HAL060087	D. WING		08/17/2020	
NAME OF PROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STAT	ΓE, ZIP CODE		
CHARLOTTE SOLIARE	5820 CAME	L ROAD			
CHARLOTTE SQUARE	CHARLOTT	E, NC 28226			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	Γ BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 338 Continued From page 23		D 338			
doorbell alerted her of their -Immediately after promptinessential visitors' temperatuabout the appropriate screet. The MA was wearing nursisurgical mask. -The MA pointed her finger residents who were identified for COVID-19 in the SCU starea with five other resident. -The MA resumed her activate the medication cart. -The MA left the enclosed of the common room where the identified as COVID-19 postive. -The MA did not put on a good gloves before entering the common area in the observation a personal care standing the center of the residents sitting in the room. None of the residents in the -The PCA was wearing nursuand a surgical mask but no shields. -The PCA was removing disfrom the tables set up for did -A second PCA entered the wearing a mask but no gow shields. -The 2 PCAs proceeded to was identified as COVID-19 to provide personal care. -Neither staff wore gowns a entering the resident's roon -The PCA clearing lunch ite.	ing the MA, took the ures and asked them ening questions. ing scrubs and a are and named four ed as tested positive sitting in the common its. Wity in the dining room and was in the residents who were sitive were co-mingling not been identified as sown, eye shields or common area. In the residents was a beginning of the e aide (PCA) was froom observing 9 in the SCU wore masks. It is sing scrubs, gloves or gown and eye sposable lunch items lining. It is unit came back with gloves, and eye with the positive to her room and eye shields when in the strength of the positive to her room and eye shields when in the strength of the positive to her room and eye shields when in the strength of the properties of the strength of the properties and eye shields when in the strength of the properties and eye shields when in the strength of the properties and eye shields when in the properties and the propert	D 338			

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DIVISION	of Health Service Regu	liation	_			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			D WING			
		HAL060087	B. WING		08/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
	10115211 011 001 1 21211			, 2 0022		
CHARLOT	TE SQUARE		IEL ROAD			
		CHARLO	TTE, NC 28226			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	MAIL	BALL
				·		
D 338	Continued From page	e 24	D 338			
	Noithar ataff ahanga	d their face masks upon				
	exiting the resident's	d their face masks upon				
	•	dents sitting at one table that				
		•				
		feet in length and 3 feet				
		as identified as tested				
	positive for COVID-19	dents sitting at two different				
		re positioned within 3 feet of ent which was sitting with				
		chair directly behind the				
		•				
		second table (One resident				
		ed positive for COVID-19). ator arrived in the common				
		e was wearing a cloth face				
	covering that was not	_				
	_	e residents' room the rooms s who were identified as				
		ad a letter "C" on their door.				
	•	ts' rooms revealed one room				
		ents (One resident was				
	•	ositive for COVID-19).				
		was 15 residents with the				
	capacity of 25 resider					
	•	emonstrated there were 5				
	empty rooms being u					
	1 7	ems until their families came				
	to remove them.	one and their farming dame				
		vho was not wearing a				
		hield arrived on the SCU				
	from an outside entra					
		medication room, put on a				
		g residents without washing				
	her hands or using ar					
	sanitizer (ABHS).					
		the common area where				
		s identified as tested positive				
	for COVID-19 was se					
		chair forward out of her way,				
	to get between two re					
		n with the opening exposing				
	gowi	are eporting exposing		<u> </u>		ı ,

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STATE FORM 8899 2SZ411 If continuation sheet 25 of 118

DIVISION	of Health Service Regu	lation	_		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					C
		HAL060087	B. WING		08/17/2020
			•		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CUADIOT	TE COLLADE	5820 CAN	IEL ROAD		
CHARLOI	TE SQUARE	CHARLO ¹	TTE, NC 28226		
040.15	CLIMMADV CT.	ATEMENT OF DEFICIENCIES		DROVIDER'S DI ANI OF CORRECTION	1 000
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(-1-)
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
		,		DEFICIENCY)	
			+		
D 338	Continued From page	e 25	D 338		
		ig scrubs, a N95 mask, and			
	no gloves.				
	-The MA walked back	into the medication room			
	after speaking to resid	dents seated at a table,			
	removed the PPE gov	wn and placed it on the			
	-	n the middle of the room.			
	-She reached and rer	moved items from a cabinet			
		nands or using an ABHS.			
	-One resident who wa	-			
	-	9 was walking around the			
	•	•			
		hallway using handrails to			
	ambulate.				
	-One resident who wa				
	positive for COVID-19	9 was ambulating with his			
	walker stopping to tou	uch handrails along the			
	walls.				
	-There was no observ	vation of often-touched			
	surfaces being cleane				
		ed a disinfectant after putting			
		own a table and wiped it dry			
		•			
		surface first with soap and			
		e disinfectant to remain in			
	place to dry.				
		ed cleaning the tables she			
	removed her gloves b				
	washing her hands or	r using an ABHS.			
	Observation of the PF	PE supply area on 08/03/20			
	at 1:54pm revealed:				
		bin in the medication room			
	on top of the refrigera				
	-The bin was labeled				
	-A note was attached				
		use face shields with COVID			
	•	e and face shields are			
	re-usable".				
	_	owns, 1 pair of goggles and			
	10 face masks.				
			1		

Division of Health Service Regulation

Interview with a PCA 08/03/20 between

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Division o	of Health Service Regu	lation			FURIVI API	PROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED)
					С	
		HAL060087	B. WING		08/17/20	020
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE		
OUADI OT	TE 00114 DE	5820 CAN	IEL ROAD			
CHARLOI	TE SQUARE	CHARLO	TTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) OMPLETE DATE
D 338	Continued From page	÷ 26	D 338			
	12:30-2:00pm reveale	ed:				
		sekeeper assigned to the				
	SCU.					
		onsible for all housekeeping				
	duties and personal c -She used one produc					
	services and dining ro					
	-The product was a d					
	cleaning closet.					
		t red in color and was				
	premixed in a spray b	ctant to spray surfaces and				
		duct after it remain in place				
	for a couple of minute					
		schedule or time to clean all				
	high touch surfaces.					
	 She cleaned when the throughout her shift. 	nings needed cleaning				
		any specific instruction on				
	how to use the disinfe					
	-No one told her that					
	needed to remain in p					
		y surface prior to applying				
	the disinfectant.					
	Interview with the MA	on 08/03/20 between				
	12:55pm-1:45pm reve					
		IA on the first shift in the				
	SCU.	equired to remain in their				
	rooms.	equiled to remain in their				
		leave the residents in their				
	rooms.					
	-She was concerned	they may fall or have an				

accident.

PPE with her last month.

-She verbally explained the proper donning and doffing of personal protective equipment.
-The HWN had reviewed the proper usage of

-The HWN had instructed the staff to wear

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		HAL060087	B. WING		08/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		5820 CAM	EL ROAD		
CHARLOT	TE SQUARE		TE, NC 28226		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 338	Continued From page	e 27	D 338		
	gowns, gloves and a personal care for COV-The staff wore gowns several COVID-19 po-She wore the same gown she changed he gown and placed it in in the hallway. -Sometimes she "lose wear her gownThe gown was very her staff was a series of the coverage	face mask when providing VID-19 positive residents. It is the entire shift since the entire shift. It is gown the entire shift. It is is gown, double bagged the the trash receptacle located the track" and "forgets" to the entire she did the gown over a chair if			
	the SCU on 08/03/20 revealed: -The staff were instructionsisting of mask, go shields prior to entering provide personal care. -The PPE was to be confident of the residents room or use. -The staff were to was medication room or use. -The staff were not expressidents were in the because they were not the residents. -The HWN was responsedures and COV procedures and COV procedures. -All staff were trained by the HWN on PPE. -The two residents on	own, gloves, and eye ng a resident's room to e. disposed of in a bin outside in the hallway. sh their hands in the se an ABHS. expected to wear PPE when common area eating of providing personal care to ensible for training and on standard infection control ID-19 infection control upon hire and checked off me that was indicated as			
	the two round tables I	OVID-19 seated together at less than 3 feet apart were er residents, and she did not			

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DIVISION	n Health Service Negu	iation			1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETÉD
			1		_	<u> </u>
			B. WING		C	
		HAL060087	D. WING		j 08/1	7/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		5820 CAN	IEL ROAD			
CHARLOT	TE SQUARE		TTE, NC 28226			
			11L, NC 20220	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
		•		DEFICIENCY)		
D 000			—			
D 338	Continued From page	28	D 338			
	think it was necessary	y to separate them any				
	further apart.	, 10 0000.010 0.00.				
	•	nmunal dining because the				
		t want to eat in their rooms,				
		ving communal dining would				
	be more efficient and					
	-The SCU residents a					
		s unsafe for them to eat				
	alone and be in their					
		he SCU were cognitively				
	•	ted to her the staff was not				
		f restricting them to their				
	own room.					
	-The resident who wa	-				
	•	remained in the same				
		nate who was not identified				
	•	VID-19 because the 5				
		l not yet been cleaned after				
	the previous residents	•				
		ing the five COVID-19				
		ts together, but she was not				
	allowed the time to do					
		dance provided from all				
	available resources m	-				
	different from all of the	=				
	-She didn't know which					
	-She wore a cloth fac	e mask because the N95s				
	were too hot and unce	omfortable; it was always				
	difficult to keep a mas					
	-The facility had an al	oundant PPE supply that				
		n the county community				
	resources.					
	-She wanted to be tol	d what to do when it came				
	to manage the SCU v	vith positive COVID-19				
	residents.	•				
	Telephone interview v	vith another MA on 08/11/20				
	at 11:20am revealed:					
	-She worked as a MA	and a PCA on the SCU.				

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-When she was assigned to work as a CNA her

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Division	of Health Service Regu	llation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					С	
		HAL060087	B. WING		08/17/2020	
					1 00/11/2020	\neg
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE SQUARE	5820 CAN	IEL ROAD			
0117111201		CHARLO	TTE, NC 28226			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(* /	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		
TAG	REGULATORT ORT	EGG IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	MAIL 57.1.2	
						\dashv
D 338	Continued From page	e 29	D 338			
	duties include housek	keeping tasks since the				
		ed to Memory Care resigned.				
		ave the staff a list of chores				
	•	ng their shift, which included				
		eas, resident's bedrooms				
	and bathrooms, and I					
		solution in a spray bottle				
	_	ousekeeping closet to clean				
	hard surfaces.	. •				
	-She sprayed tables,	ledges, hand rails and wiped				
	off the solution with a	cloth or paper towel.				
	-She did not wait any	length of time before wiping				
	the area down.					
		nat the directions were for				
	proper usage of the c					
		any guidance/instructions on				
	- ·	ts to use or how to properly				
	use them.					
		ientation packet by the				
		ager (BOM) upon hire that				
	included infection cor					
	and return to the BON	o read the information, sign				
	_	n infection control class or				
	presentation or any s					
	instructions upon hire	!				
		on PPE by the Health and				
	Wellness nurse recer					
		o wear gowns, face mask or				
		nd shoe coverings if she				
	went into a COVID po					
		o remove PPE outside of the				
	room, put it in a plasti	ic bag and place the bag in				
	the trash receptacle is					
	-Hand sanitizers were	e in the medication room and				
	on the medication car	rt for staff to use.				
	-There was a commo	n bathroom in the front hall				
	for staff to wash their	hands with soap and water.				J
	-The staff had been in					
	Administrator and the	HWN to inform them if any				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			1		
		1141.00007	B. WING		C
		HAL060087	B. W		08/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		5820 CAM	EL ROAD		
CHARLO	TE SQUARE	CHARLO1	TE, NC 28226		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J (V5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(-/
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 338	Continued From page	2.30	D 338		
D 000	Continued From page	5 30	2 000		
	resident has sympton	ns of shortness of breath,			
	cough or a fever.				
		with the Maintenance staff on			
	08/10/20 at 8:44am re				
	-One of his duties wa	55 5			
	machine" in the SCU.				
		e used a fine mist to apply			
	disinfectant cleaning				
		cleaned prior to fogging.			
		responsible for cleaning the			
	area before he arrive	d with the fogging machine.			
		ogging machine in the			
	COVID-19 positive ro				
	-The staff used the El	PA approved disinfectant			
	product diluted in wat	ter in a spray bottle kept in			
	the housekeeping clo				
	-The Maintenance ma				
	disinfectant mixed wit	th water into the spray bottle.			
	-The staff should spra	ay the solution onto hard			
	surfaces and wait 10	minutes before wiping the			
	surface down.				
	-He did not know who	trained the PCAs on using			
	the cleaning products	S.			
	Telephone interview v				
	_	at 10:32am revealed:			
		e purchase of the fogging			
		OVID-19 outbreak as the			
	I -	y to disinfect the facility.			
		proved disinfectant with the			
	operation of the mach				
	-He did not clean the	area before using the			
	machine.				
	-He was trained on th	ne proper usage of the			
	machine by the comp	any it was purchased from.			
	-He did not remembe	r the name of the company.			
	-He used the fogging	machine throughout the			
		the residents stayed in their			

rooms.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		_
		HAL060087	B. WING		C 08/17/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CHARLOT	TE SQUARE	5820 CAN	IEL ROAD		
CHARLUI	IE SQUARE	CHARLO	TTE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 338	Continued From page	e 31	D 338		
	were seated in the co-There was no special fogging applicationIt took about 10 minu-The SCU was cleaned 2-3 times a week. Follow up email to a to-	ooms while the residents ommon area. Il cleaning before the utes to dry. The ded with the fogging machine the lelephone interview with the			
	County Environmental Health Specialist on 08/10/20 at 3:44pm revealed:				
	surfaces for disinfecti	•			
		to disinfect the areas before			
	and after use and tha proper disinfecting.	t would be the guidance for			
	Another observation upon entry into the SCU on 08/13/20 between 8:00am-9:15am revealed: -A PCA allowed entry of two essential visitors through a locked door after the doorbell alerted her of their arrivalThe PCA was wearing a surgical mask but no				
		he two essential visitors ometer providing very low			
	readings of less than	90 degrees for both visitors. SCU there were 15 residents			
	length and 3 feet wide -Two residents were seating breakfast, seat -After the two residen finished their breakfast	ere were two tables 6 feet in e set up along one wall. sitting at one of the tables ted less than 3 feet apart. Its that were seated together st, they ambulated to a 5 ft evision, and they sat down			
	less than 5 ft apart at	different times on the sofa. g in a wheelchair that was			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		HAL060087	B. WING		08/1	7/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
			IEL ROAD	•		
CHARLOT	TE SQUARE		TTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	e 32	D 338			
	6 feet apart. -The PCA did not atteresidents and allowed. -The PCA rolled the rewhere the two resider on the sofa. -The PCA placed the the table and went to -She did not wash he the resident's food trato the living room. -The PCA placed the the table in front of he bottle, and food contarthe resident picked eat. -The PCA did not cleawash the resident's he resident to the table.	r hands before she removed by from a cart and returned resident's breakfast tray, on er opened her milk, water				
	8:00am-9:15pm reveal -The current census of residents. -She was required to	on the SCU was 15 self-screen for COVID-19 by				
	a questionnaireShe did not complete sheet when she arrive the only person availaresidentsThe thermometer usbroken and the MA wimedication cart to getworked.	e and answer questions on e a COVID-19 screening ed at work because she was able to take care of the ed for screenings was ould have to open the t another thermometer that infection control and she				

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knew she was supposed to wash and disinfect

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		FIED
		HAL060087	B. WING		08/1	17/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		5820 CAM	EL ROAD			
CHARLOT	TE SQUARE		TE, NC 28226			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON .	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP	D BE	COMPLETE DATE
D 338	Continued From page	e 33	D 338			
	the tables between re					
		upposed to wash residents'				
		ands before serving the				
	residents their breakfa	•				
		parate the residents 6 feet				
	apart because they w	ould get agitated.				
	Interview with the MA	on 08/13/20 at 9:30am				
	revealed:	1011 00/13/20 at 9.30am				
		orked sometimes and other				
	times it did not work.	inted comounies and other				
		er thermometer from the				
	medication cart, and i					
	accurate reading.	it did not provide an				
		second thermometer had				
	been replaced but it s					
	accurate reading.					
	-She was responsible	for screening all the				
	residents and staff on	<u> </u>				
	-She did not screen re	esident's temperatures daily.				
	-There was no entry of	on the electronic Medication				
	Administration Record	ds (eMARs) to document				
	resident's temperature	es during first or second				
	shift.					
	-Residents and staff v	were screened using the				
		vided inaccurate readings.				
		d the staff screening logs				
		WN responsibility to collect				[
	them and review then					
		VN "a few days ago" that the				
		ken, and she did not get a				
	replacement yet.	and the LIVAIN Last were desired				
		en the HWN last reviewed				
	the COVID-19 staff so					
	-She was told to subn					[
	temperatures weekly	U LIE TIVIN.				[
	Telephone intonvious	vith a Registered Nurse				
	(RN) from the LHD or					[
	revealed:	1 00/00/20 at 9.00am				
	ouiou.		1	1		i .

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
				-	C	
		HAL060087	B. WING		08/17/2020	
			<u> </u>		1 00/1//2020	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
CHARLO	TTE SQUARE	5820 CAME				
		CHARLOT	ΓE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 338	Continued From page	e 34	D 338			
	-The facility was in the COVID-19. -The first outbreak was residents who identified to COVID-19 on the second of the present there was the positive for COVID-19. -The Administrator and 07/15/20 the facility has positive for COVID-19. -During the second of the present there was who were identified was COVID-19. -There were 2 of 11 compositive test results the following testing positions to their sympton-The last positive test. She emailed the Admiguidelines with the new NCDHHS guidelines and (07/15/20). -She instructed them residents daily for sig COVID-19 by checking any symptoms of CO-She highlighted their guidelines for "facilities COVID-19 perform the staff if there are one of identified continue repasymptomatic previous staff approximately evidays since the most reshe instructed them.	eir second outbreak of as in April 2020 with 13 ed with positive test results Assisted Living side. orted on 04/28/20 and after ed with no additional positive and the HWN informed her on had four residents who tested 3. butbreak beginning 07/10/20 byere 3 staff and 11 residents byith positive test results for of residents who indicated hat died within the 3 weeks betive for COVID-19 or the ms. It was a resident on 07/21/20. Ininistrator the LHD becessary links for CDC and for LTC facilities the same to monitor staff and has and symptoms of hig temperatures and noting VID-19. Instructions with LHD bes with identified cases of histing on all residents and hor more cases of COVID-19, hopeat viral testing of all husly negative residents and hyery 3-7 days of at least 14 hecent positive result". to review the Long-Term				
	-There were 2 of 11 of positive test results the following testing positions on the following testing positions of their symptoral control of their symptoral control of their symptoral control of their symptoral control of their symptoms of their symptoms of the control of their symptoms of th	nat died within the 3 weeks tive for COVID-19 or the ms. was a resident on 07/21/20. ministrator the LHD ecessary links for CDC and for LTC facilities the same to monitor staff and ns and symptoms of ng temperatures and noting VID-19. nstructions with LHD es with identified cases of esting on all residents and or more cases of COVID-19, peat viral testing of all usly negative residents and very 3-7 days of at least 14 recent positive result".				

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attaching it to them in an email.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			, ,	E SURVEY PLETED		
		HAL060087	B. WING		08	C 3/17/2020
NAME OF F	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	7 7 D CODE	1 00	
NAME OF P	ROVIDER OR SUPPLIER		MEL ROAD	E, ZIP CODE		
CHARLO	TTE SQUARE		OTTE, NC 28226			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE
D 338	Continued From page	35	D 338			
	capacity to test all restacility. -She instructed them tested positive for CO - If the facility had mu confirmed in residents they be confined to or facility to prevent the -She instructed them the care of COVID-19 -She instructed them universal use of facer the facilityShe instructed them infection prevention gapproved cleaning susused in the care of coving susused in the facility.	Itiple COVID-19 cases s, it was recommended that ne wing or location of the spread of COVID-19. to assign dedicated staff to positive residents. to use PPE, including masks for all staff while in to follow appropriate uidelines and to use EPA pplies.				
	-Their recommendatic separating all resident COVID-19 be isolated ideally 20 days from to identified as testing numbers. Their recommendatic communal dining, and residents who indicate COVID-19 in a room a positive residents with and COVID-19 negations staff in a separate are appropriate PPE whe positive residents.	8/08/20 at 1:00pm revealed: ons included isolating and ts who tested positive for d for at least 14 days, and he residents who were egative for COVID-19. ons included stopping d group activities, placing ed as testing positive for alone, cohort COVID-19 n dedicated staff in one area live residents with dedicated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE SUR COMPLETE			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		LETED
						С
		HAL060087	B. WING		08/	17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE		
		5820 CAI	MEL ROAD			
CHARLOT	TTE SQUARE	CHARLO	TTE, NC 28226			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	- CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 338	Continued From page	e 36	D 338			
	ourrently experiencing	~				
	currently experiencing	y. each out to the LHD to				
	_	es or clarification of the				
	guidance provided ur					
		utbreak beginning 07/10/20				
	_	vas 3 staff and 11 residents				
		e test results for COVID-19.				
	T	11 of residents who were				
		e test results that died within				
	the 3 weeks following					
	COVID-19 or the ons	- -				
		, ,				
	Telephone interview v	with the previous Special				
		CC) on 08/05/20 at 2:07pm				
	revealed					
	-She last tested nega	tive for indications of				
	COVID-19 on 07/06/2	20.				
	-She was not instruct	ed to retest after her				
	negative test.					
	I -	onsible for managing all staff				
	_	Control (IC) policies and				
	procedures.					
		IWN not checking off staff				
	on IC tasks for annua					
		necked off on proper putting				
	gowns, and gloves, a	E consisting of masks,				
		o wear PPE gowns, and				
	gloves when providin	•				
		espiratory diseases like				
		never provided a formal				
		to the Wellness Nurse				
		Certified Nursing Assistant.				
		per use of PPE by staff on				
		spot corrections, but staff				
	continued to be non-	•				
		SCU were not isolated to				
	their room, appropria	tely social distancing				
		d more staff to ensure these				
	guidelines were follow					

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D 14/10	
D 14/10	
HAL060087 B. WING 08/	17/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
CHARLOTTE SQUARE 5820 CAMEL ROAD	
CHARLOTTE, NC 28226	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338 Continued From page 37 D 338	
-The capacity of the SCU was 25 residents and the census on her last day of work (07/14/20) was 24 residents with two residents in the hospital. -There was not a plan put in place to isolate the residents who tested positive for COVID-19. -There was not a plan to acquire additional staff because the she was told the facility was utilizing too many contract PCAs and MAs. -She reported her findings and all her concerns to the Administrator and the HWN. -The Administration and HWN. -The Administration and HWN to the tri was the trained and the roncerns to the trained and the staff to appropriate use of PPE. -She had observed staff assigned in the SCU	

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	D DI AN OF CORRECTION			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILBING.	A. BUILDING:		
		HAL060087	B. WING		08/17	7/2020
NAME OF PRO	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHARLOTT	E SQUARE	5820 CAN	IEL ROAD			
OHARLOTT	L OQUAILE	CHARLO	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	: 38	D 338			
	themShe was very "hands staff about infection or handwashing, PPE us high touch surfacesThe residents who w positive were not isola other residents identifibecause it was not satheir rooms aloneShe suggested movinidentified as COVID-1 residents identified as AdministratorShe was not responsive as COVID-19 positive of today (08/12/20 and all the residents identified as remain in the same roas COVID-19 positive of today #26 since the last 07/21/20 and all the residents identified as 107/21/20 and all the residents of all the staff outbreakThe staff were responsible testing of all the staff outbreakThe staff were responsible testing all staff meeting instructed to remain hubring all staff meeting on signs/symptoms to not have a sign-in rosmeetingsShe instructed the stresidents' temperature of the SCU residents COVID-19 symptoms	s-on" when educating the control to include se, and proper cleaning of the ere identified as COVID-19 ated to their rooms from fied as COVID-19 negative fe for them to remain in the gresidents who were 9 positive away from a COVID-19 negative to the sible for the decision for a COVID-19 negative to from with residents indicated standard tested positive on the esident tested positive on the esident tested positive on the esidents no longer required for the surveillance and for the surveillance and for the surveillance and for the surveillance and for their own selful to work and were some if they became sick, and she provided education of report to her, but she did ter or minutes from those for the sculpture of the sculpture from those the sculpture from the sculpture from those sto her every Monday, and to tell the SCU staff to stories with the sculpture for the sculpture from those stories and report any				

do.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060087	B. WING		C 08/17/2020	
	ROVIDER OR SUPPLIER	STREET ADI		TE, ZIP CODE	1 00/11/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 338	-She did not go behin residents' vital signs a -After the previous SC daily to check on the -All the staff and resic COVID-19 negative with days for 14 days becaget the laboratory service 08/07/20 to retest the staff. -When she reached common up" until 08/21/20. -She was going to test identified as COVID-1-she received an emathe LHD-RN on 07/15 for laboratory service. She did not reach out because she felt "it when the staff were offer they refused to test. -She did not create a prevention plan and provention plan and provention proven	d the staff to assess the and symptoms every day. CC left, she visited the SCU residents and staff. Idents who identified as were not retested every 3-7 ause it was a challenge to vice to come that frequently. De did not show up on negative residents and but to them via email on and her they were "booked at all the staff and residents 19 negative today (08/12/20). Dead and telephone call from 16/20 with all the resources as at to the LHD for assistance could take too long". Dered COVID-19 infection policies prior to the outbreak are of disinfecting high touch incing, isolation, and as to have in place for the 19. The staff to follow their training in control policy in place for which included PPE and the surfaces. Information from the LHD RN the previous outbreak in	D 338			

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-When she observed staff not following their

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: COMPLETED COMPLETED COMPLETED COMPLETED NAME OF PROVIDER OR SUPPLIER CHARLOTTE SQUARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) MULTIPLE CONSTRUCTION A. BUILDING: B. WING CHORLOTTE, SC DE CHARLOTTE, XC 28226 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETED (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED (X5) DE PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETED (X5) DE PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETED (X5) MULTIPLE CONSTRUCTION A. BUILDING: COMPLETED (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE	Division of Health Service Regulation						APPROVED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SE20 CAMEL ROAD CHARLOTTE, NC 28226 OAJ ID PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D 338 D 338 Continued From page 40 D 338 Training and facility policies, she corrected them immediately. -She did not receive the recent email dated O7715/20 addressed to her email address because it might have gone into her spam folder. -She spoke to the LHD RN during the current outbreak that began 07/10/20. -The HWN was responsible for ensuring the screening and weekly testing of COVID-19 negative staff and residents to the LHD. -She was not aware of any COVID-19 positive related deaths of residents. -The residents' death since the outbreak were all hospice residents. -She knew the HWN had problems getting weekly testing completed for the staff and residents because the facilitys laboratory service provider was not available to perform testing weekly. -Not all the staff was compliant with testing. -She did not reach out to the LHD for further assistance or guidance. -If she reached out via the links provided in the email from the LHD it would not been a solution to get all the staff to consent to testing. -The LHD was not going perform COVID-19	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '			
CHARLOTTE SQUARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) D 338 Continued From page 40 training and facility policies, she corrected them immediately. -She did not receive the recent email dated 07/15/20 addressed to her email address because it might have gone into her spam folder. -She spoke to the LHD RN during the current outbreak that began 07/10/20. -The HWN was responsible for ensuring the screening and weekly testing of COVID-19 negative staff and residents. -The HWN was expected to report all COVID-19 positive staff and residents to the LHD. -She was not aware of any COVID-19 positive related deaths of residents. -The residents' death since the outbreak were all hospice residents. -She knew the HWN had problems getting weekly testing completed for the staff and residents because the facility's laboratory service provider was not available to perform testing weekly. -Not all the staff was compliant with testing. -She did not reach out to the LHD for further assistance or guidance. -If she reached out via the links provided in the email from the LHD it would not been a solution to get all the staff to consent to testing. -The LHD was not going perform COVID-19			HAL060087	B. WING		1	
CHARLOTTE SQUARE CHARLOTTE, NC 28226 (24) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRI	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
(AU) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 338 Continued From page 40 training and facility policies, she corrected them immediatelyShe did not receive the recent email dated 07/15/20 addressed to her email address because it might have gone into her spam folderShe spoke to the LHD RN during the current outbreak that began 07/10/20The HVN was responsible for ensuring the screening and veekly testing of COVID-19 negative staff and residents to the LHDShe was not aware of any COVID-19 positive related deaths of residentsThe residents' death since the outbreak were all hospice residentsShe knew the HWN had problems getting weekly testing completed for the staff and residents because the facility's laboratory service provider was not available to perform testing weeklyNot all the staff was compliant with testingShe did not reach out to the LHD for further assistance or guidanceIf she reached out via the links provided in the email from the LHD it would not been a solution to get all the staff to consent to testingThe LHD was not going perform COVID-19	CHARLOT	TE SOUADE	5820 CA	MEL ROAD			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) D 338 Continued From page 40 training and facility policies, she corrected them immediately. -She did not receive the recent email dated 07/15/20 addressed to her email address because it might have gone into her spam folderShe spoke to the LHD RN during the current outbreak that began 07/10/20The HWN was responsible for ensuring the screening and weekly testing of COVID-19 negative staff and residentsThe HWN was expected to report all COVID-19 positive staff and residents to the LHDShe was not aware of any COVID-19 positive related deaths of residentsThe residents' death since the outbreak were all hospice residentsShe knew the HWN had problems getting weekly testing completed for the staff and residents because the facility's laboratory service provider was not available to perform testing weeklyNot all the staff was compliant with testingShe did not reach out to the LHD for further assistance or guidanceIf she reached out via the links provided in the email from the LHD it would not been a solution to get all the staff to consent to testingThe LHD was not going perform COVID-19	CHARLOI	TE SQUARE	CHARLO	OTTE, NC 28226			
training and facility policies, she corrected them immediately. -She did not receive the recent email dated 07/1/5/20 addressed to her email address because it might have gone into her spam folder. -She spoke to the LHD RN during the current outbreak that began 07/10/20. -The HWN was responsible for ensuring the screening and weekly testing of COVID-19 negative staff and residents. -The HWN was expected to report all COVID-19 positive staff and residents to the LHD. -She was not aware of any COVID-19 positive related deaths of residents. -The residents' death since the outbreak were all hospice residents. -She knew the HWN had problems getting weekly testing completed for the staff and residents because the facility's laboratory service provider was not available to perform testing weekly. -Not all the staff was compliant with testing. -She did not reach out to the LHD for further assistance or guidance. -If she reached out via the links provided in the email from the LHD it would not been a solution to get all the staff to consent to testing. -The LHD was not going perform COVID-19	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	(X5) COMPLETE DATE
immediately. -She did not receive the recent email dated 07/15/20 addressed to her email address because it might have gone into her spam folder. -She spoke to the LHD RN during the current outbreak that began 07/10/20. -The HWN was responsible for ensuring the screening and weekly testing of COVID-19 negative staff and residents. -The HWN was expected to report all COVID-19 positive staff and residents to the LHD. -She was not aware of any COVID-19 positive related deaths of residents. -The residents' death since the outbreak were all hospice residents. -She knew the HWN had problems getting weekly testing completed for the staff and residents because the facility's laboratory service provider was not available to perform testing weekly. -Not all the staff was compliant with testing. -She did not reach out to the LHD for further assistance or guidance. -If she reached out via the links provided in the email from the LHD it would not been a solution to get all the staff to consent to testing. -The LHD was not going perform COVID-19	D 338	Continued From page	40	D 338			
laboratory service provider to come and perform the testingShe did not consider obtaining a decline to consent to test from the staffShe knew staff were not documenting their daily screenings and performing the residents'		training and facility poimmediatelyShe did not receive to 07/15/20 addressed to because it might have she spoke to the LHI outbreak that began 0The HWN was resposcreening and weekly negative staff and residents and residents are sidentsThe HWN was expect positive staff and residents are related deaths of residentsShe was not aware or related deaths of residentsShe knew the HWN Intesting completed for because the facility's was not available to pendid hot reach out assistance or guidance. If she reached out via email from the LHD it to get all the staff to center and the LHD was not go weekly testing, and the laboratory service protestingShe did not consider consent to test from the LShe knew staff were	he recent email dated of her email address agone into her spam folder. D RN during the current 17/10/20. Insible for ensuring the testing of COVID-19 idents. Interested to report all COVID-19 dents to the LHD. If any COVID-19 positive dents. Insince the outbreak were all the problems getting weekly the staff and residents alaboratory service provider terform testing weekly. It to the LHD for further is a the links provided in the would not been a solution consent to testing. Ing perform COVID-19 to get a wider to come and perform obtaining a decline to the staff. Into documenting their daily				

-The HWN was performing the test without

attached documents and websites.

-She needed more help than emails with links to

-She needed someone to show up and tell her

consent to obtain them.

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7.1. 56.125.1.16.			
		HAL060087	B. WING		C 08/17/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	FE. ZIP CODE		
			MEL ROAD			
CHARLOT	ITE SQUARE		TTE, NC 28226			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 338	Continued From page	: 41	D 338			
	COVID-19She did not get the a the state and local he -She did not create a					
	COVID-19.	A NCAC 13F .0604(e)				
	Refer to Tag 358, 10A Medication Administra	` ,				
	Refer to Tag 0465, 10 Special Care Staff.	A NCAC 13F 1308(a)				
	recommendations est and NC DHHS for infet transmission during the related to the improper order to effectively eliascreening staff or resistant providing reliable them. COVID positive residents to dine and without any regard for cohorting COVID positive residents into there was potential to appropriate PPE when donning PPE correctly testing staff or retesting residents as instructed residents residing in the standard procession of the standard proce	ne COVID-19 pandemic er usage of disinfectants in minate the coronavirus; not dent temperatures and not mometers to do so; allowing ents and COVID negative gather in common areas social distancing; not itive residents and COVID to separate rooms when do so; staff not donning the n necessary and also not y when indicated; and not no COVID negative d all of which resulted in 11 the facility diagnosed with ization, 2 deaths, and 3 staff				
	diagnosed with COVII resulted in serious ha constitutes a Type A1	rm and neglect which				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTI				E SURVEY PLETED	
						С
		HAL060087	B. WING		08	3/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
CHARLO1	TTE SQUARE		MEL ROAD			
			OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 338	Continued From page	e 42	D 338			
	The facility provided a accordance with G.S. this violation.	a plan of protection in 131D-34 on 08/03/20 for				
	CORRECTION DATE VIOLATION SHALL N 16, 2020.	FOR THE TYPE A1 IOT EXCEED SEPTEMBER				
D 358	10A NCAC 13F .1004 Administration	I(a) Medication	D 358			
	(a) An adult care hor preparation and admi prescription and nonby staff are in accorda (1) orders by a licens which are maintained	Medication Administration me shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies				
	This Rule is not met TYPE A2 VIOLATION					
	reviews, the facility farmedications as ordered practitioner for 6 of 7 (Residents #2, #3, #4 several medications to medication to control medication for nerved mood stabilizers, a man overactive bladder for bipolar disorder ar (Resident #3); medications as ordered.	ed by a licensed prescribing sampled residents ., #5, #6 and #7), including o control blood sugar, a blood pressure, a pain, an anticoagulant, edication for cholesterol and r (Resident #5); medications				

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:		
		HAL060087	B. WING		C 08/17/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
011451.03	TE 00114 DE	5820 CAME	L ROAD			
CHARLO	TE SQUARE	CHARLOT	E, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	ETE
D 358	mood stabilizer (Residerian, anxiety, acid ref (Resident #2), medications for pain of depression, and respill addition, the facility 15 residents, residing received their medicatesidents on the Assistration of the facility sand Procedures reveally and Procedures reveally and Procedures reveally and Procedures reveally a medication error director immediately assistant as a medication of the facility sand Procedures reveally a medication error director immediately assistant as a medication of the facility sand Procedures reveally a medication of the facility of the faci	ol blood pressure, and a dent #4), medications for lux, and high blood pressure ations for pain, anxiety and Resident #6), and control, high blood pressure, ratory issues (Resident #7). If alied to ensure 15 out of in the Special Care Unit, tion on 08/08/20, and two sted Living community tions on 08/08/20 and S Medication Errors Policy aled: occurs, notify the Wellness and follow his/her directions. The require the completion of the following: a resident obecause it was not offered cation Incident Report form it signed by the Wellness e Director (ED), with a plan	D 358			
		long acting insulin used to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		HAL060087	B. WING		1	7/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE SQUARE	5820 CAM				
		CHARLOT	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	2 44	D 358			
	treat elevated blood s	sugar.				
	Review of Resident #5's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for Levemir Flex Pen 30 units to be administered twice daily at 8:00am and 8:00pm. Call the physician if the blood sugar is less than 60 or greater than 500. -Levemir was not documented as administered at 8:00am or 8:00pm on 08/08/20 and 08/09/20. -There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes. -Resident #5's blood sugar from 08/01/20 through 08/07/20 and 08/10/20 through 08/13/20 at 8:00am was documented in the range of 103 to 275.					
	on 08/08/20 or 08/09/	sugar was not documented '20. am Resident #3's blood				
	facility's contracted pl 2:45pm revealed Res Pen, 30 units twice da	aily, was last dispensed on				
	2:45pm revealed Resident #3's Levemir Flex Pen, 30 units twice daily, was last dispensed on 07/22/20 for a 30-day supply. Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a Levemir Flex Pen with a computer-generated pharmacy label attached to the pen and directions to administer 30 units twice a dayThe label had a dispense date of 07/22/20.					

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b. Review of Resident #5's FL2 dated 05/22/20

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. BOILDING.	A. BUILDING.		
		HAL060087	B. WING		08	C 3/ 17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
CHVBI O	TTE SQUARE	5820 CAI	MEL ROAD			
OHARLO	TIE SQUARE	CHARLO	OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 45	D 358			
		n order for a Novolog Flex ulin used to treat elevated				
	blood sugar, inject 10					
		5's August 2020 eMAR from				
	08/01/20 through 08/	er-generated entry for				
	· ·	ect 10 units twice daily, to				
	be administered at 12					
	-Novolog 10 units wa	s not documented as lpm or 5:00pm on 08/08/20				
	and 08/09/20.	phil of 3.00phil off 06/06/20				
	-There was no reasor	n documented on the eMAR				
	under "Exceptions" or notes.	in the electronic progress				
	Telephone interview v	vith the pharmacist at the				
		narmacy on 08/17/20 at				
		ident #5's Novolog Flex day, was filled on 06/15/20				
	and on 7/23/20 for a 2	-				
	Observation of Resid					
	available for administ 12:05pm revealed:					
	-There was a Novolog					
		oharmacy label attached to s to administer 10 units				
	twice a day.	io to dariminotor 10 armo				
	-The label had a disp	ense date of 07/23/20.				
	c. Review of Residen	t #5's FL2 dated 05/22/20				
		n order for a Victoza Pen,				
	daily.	ugar, inject 1.8mg once				
		5's August 2020 eMAR from				
	08/01/20 through 08/					
		er-generated entry for a ng to be administered daily				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
ANDILAN	or dortheorion	IDENTIFICATION NOMBER.	A. BUILDING: _			
		HAL060087	B. WING		C 08/17/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE COUADE	5820 CAMI	EL ROAD			
CHARLO	TE SQUARE	CHARLOT	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 46	D 358			
	08/08/20 or 08/09/20 -There was no reasor under "Exceptions" or notes.	n documented on the eMAR r in the electronic progress				
	facility's contracted pl 2:45pm revealed Res	with the pharmacist at the harmacy on 08/17/20 at hident #5's Victoza pen on 06/08/20, 07/23/20 and day supply.				
	Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a Victoza pen with a computer-generated pharmacy label attached to the pen and directions to administer 1.8mg daily. -The label had a dispense date of 07/23/20.					
	revealed there was a	t #5's FL2 dated 05/22/20 n order to check and record ar (FSBS) before meals and				
	08/01/20 through 08/ -There was a comput and record FSBS 4 tii 11:30am, 4:30pm, an physician if the FSBS than 500The FSBS was not d 08/08/20 and 08/09/2 4:30pm, or 8:00pmThere was no reasor under "Exceptions" or notes.	er-generated entry to check mes a day, at 7:30am,				

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Division of Fleatin Service Regulation	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	COMPLETED
	С
HAL060087 B. WING	08/17/2020
TIALOUGO	1 00/11/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
CHARLOTTE SQUARE 5820 CAMEL ROAD	
CHARLOTTE, NC 28226	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C	CORRECTION (X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIVE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TI	
	,
D 358 Continued From page 47	
08/07/20 and 08/10/20 through 08/13/20 at	
8:00am was documented in the range of 103 to	
275.	
-Resident #5's blood sugar from 08/01/20 through	
08/07/20 and 08/10/20 through 08/13/20 at	
11:30am was documented in the range of 151 to	
268.	
-Resident #5's blood sugar on 08/10/20 was	
documented as 458 at 7:30am and 386 at	
11:30am.	
e. Review of Resident #5's FL2 dated 05/22/20	
revealed there was an order for Losartan	
Potassium 100mg once daily, a medication used	
to treat elevated blood pressure.	
to treat elevated blood pressure.	
Review of Resident #5's August 2020 eMAR from	
08/01/20 through 08/13/20 revealed: -There was a computer-generated entry for	
Losartan Potassium 100mg to be administered	
daily at 8:00am.	
-Losartan Potassium was not documented as	
administered daily on 08/08/20 and 08/09/20.	
-There was no reason documented on the eMAR	
under "Exceptions" or in the electronic progress	
notes.	
Telephone interview with the pharmacist at the	
facility's contracted pharmacy on 08/17/20 at	
2:45pm revealed:	
-Thirty tablets of Losartan Potassium were	
dispensed for Resident #5 on 06/01/20.	
-Thirty-one tablets of Losartan Potassium 100mg	
were dispensed for Resident #5 on 07/01/20 and	
on 07/31/20.	
Observation of Resident #5's medications	
available for administration on 08/13/20 at	
12:05pm revealed:	

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-There was a blister pack of thirty-one Losartan

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLI	I I E D
		HAL060087	B. WING		08/1	; 7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
		5820 CAMI	EL ROAD			
CHARLOT	TE SQUARE	CHARLOT	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	and directions to adm -The label had a dispiThe start date on the administration of Losa -There were twenty-e blister pack. f. Review of Resident revealed there was al blood pressure daily, systolic pressure was the diastolic pressure 50. Review of Resident # 08/01/20 through 08/ -There was a comput and record blood pres physician if the systol or below 100, or the of 100 or below 50Resident #5's blood documented as admin and 08/09/20There was no reasor under "Exceptions" or notesResident #5's blood through 08/07/20 and at 8:00am was docum 117/58 to 153/80Resident #5's blood on 08/10/20 at 8:00ar g. Review of Residen revealed there was an	pharmacy label attached sinister one tablet daily. ense date of 07/31/20. e blister pack for the artan was 08/10/20. eight tablets remaining in the artan was 08/10/20 in order to check and record notify the physician if the above 180 or below 100, or was above 100 or below 5's August 2020 eMAR from 13/20 revealed: er-generated entry to check assure daily, notify the ic pressure was above 180 diastolic pressure diattolic pressure dia	D 358			
	medication used to tre disorder, 30mg twice	eat depression and anxiety daily.				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL060087	B. WING		C 08/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CHARLOTTE SQUARE 5820 CAMI					
			TE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page 49		D 358		
	08/01/20 through 08/ -There was a comput Duloxetine 30mg to b 8:00am and 8:00pmDuloxetine was not of twice daily on 08/08/2 -There was no reasor "Exceptions" or in the Telephone interview w facility's contracted pl 2:45pm revealed: -Sixty tablets of Dulox for Resident #5 to the	er-generated entry for e administered twice daily at documented as administered to or 08/09/20. In documented on the eMAR electronic progress notes. With the pharmacist at the marmacy on 08/17/20 at Retine 30mg were dispensed of facility on 06/01/20. Ouloxetine 30mg were Int #5 to the facility on			
	and directions to adm -One blister pack was second blister pack w -The label had a dispoThe date the medica was started was 08/1 -There were twenty-s the morning blister pa	packs of thirty-one ets each with a charmacy label attached inister one tablet twice daily. Is labeled "morning" and the ras labeled "evening". ense date of 07/31/20. tion from the blister pack 0/20. even tablets remaining in			
	revealed there was a	t #5's FL2 dated 05/22/20 n order for Risperidone otic medication used to treat			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			_		C	
		HAL060087	B. WING		1	//2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE SQUARE	5820 CAME				
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	TE, NC 28226	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page 50		D 358			
	bipolar disorder, twice	e daily.				
	Review of Resident # 08/01/20 through 08/7-There was a comput Risperidone 0.25mg to 8:00pmRisperidone was not administered twice daron administration of the second administration of Reside and directions to administration administration of Reside and directions to administration administration administration of the second administration administ	5's August 2020 eMAR from 13/20 revealed: er-generated entry for wice daily at 8:00am and documented as ally on 08/08/20 or 08/09/20. In documented on the eMAR in the electronic progress with the pharmacist at the narmacy on 08/17/20 at eridone 0.25mg were nt #5 on 06/01/20. Risperidone were dispensed 1/01/20 and on 07/31/20. ent #5's medications ration on 08/13/20 at packs of thirty-one				
	second blister pack w -Both pharmacy label and a dispense date of -The date the medical was started was 08/1 -There were twenty-sthe morning blister page	ras labeled "evening". s had Resident #5's name of 07/31/20. tion from the blister pack 0/20. even tablets remaining in				

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i. Review of Resident #5's FL2 dated 05/22/20

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Division c	of Health Service Regu	lation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		TE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		CON	MPLETED
						С
		HAL060087	B. WING		o	8/17/2020
		070557.15		TE 7/0 0005		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE		
CHARLOTTE SQUARE		MEL ROAD				
		CHARLO	TTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 51	D 358			
		n order for Gabapentin medication used to treat				
	from 08/01/20 through -There was a comput Gabapentin 400mg to at 8:00pmGabapentin was not administered on 08/08:00pmThere was no reason under "Exceptions" on notes. Telephone interview vifacility's contracted pl 2:45pm revealed: -Thirty tablets of Gabadispensed for Reside	ter-generated entry for be administered once daily documented as 8/20 and 08/09/20 at an documented on the eMAR in the electronic progress with the pharmacist at the harmacy on 08/17/20 at eapentin 400mg were ent #5 on 06/01/20.				
	for Resident #5 on 07 Observation of Resident available for administ 12:05pm revealed: -There was a blister process of the blister pack and described to tablet dailyThe label had a dispertable the medical was started was 08/1There were twenty-e blister pack.	tration on 08/13/20 at pack of thirty-one ablets with a pharmacy label attached to directions to administer one pense date of 07/31/20. ation from the blister pack				

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revealed there was an order for Donepezil 5mg

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	CONSTRUCTION	(X3) DATE S COMPL	
						;
		HAL060087	B. WING		08/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE SQUARE	5820 CAME				
			TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	÷ 52	D 358			
	once daily, a medicat progression of demer					
	08/01/20 through 08/ -There was a compute Donepezil 5mg daily to 8:00pmDonepezil was not do daily on 08/08/20 or 0There was no reason under "Exceptions" or notes. Telephone interview of facility's contracted plots 2:45pm revealed: -Thirty tablets of Done for Resident #5 on 06Thirty-one tablets of	er-generated entry for to be administered at eccumented as administered 18/09/20. In documented on the eMAR In in the electronic progress with the pharmacist at the harmacy on 08/17/20 at epezil 5mg were dispensed				
	Observation of medications available for administration on 08/13/20 at 12:05pm revealed: -There was a blister pack of thirty-one Donepezil 5mg tablets with a computer-generated pharmacy label attached to the blister pack and directions to administer one tablet dailyThe label had a dispense date of 07/31/20The date the medication from the blister pack was started was 08/10/20There were twenty-eight tablets remaining in the blister pack. k. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order for Aspirin 81mg once daily, an over the counter medication used for thinning the blood.					

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Review of Resident #5's August 2020 eMAR from

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION (X	
			A. BUILDING: _		COMPLETED
		HAL060087	B. WING		C 08/17/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
CHARLOT	TE SQUARE		IEL ROAD		
			TTE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	: 53	D 358		
D 358	08/01/20 through 08/ -There was a compute Aspirin 81mg, to be a -Aspirin was not docudaily on 08/08/20 and -There was no reason under "Exceptions" or notes. Telephone interview v facility's contracted pt 2:45pm revealed: -Thirty tablets of Aspir Resident #5 on 06/01 -Thirty-one tablets of dispensed for Reside 07/31/20. Observation of Reside available for administ 12:05pm revealed: -There was a blister pt 81mg tablets with a contract of the computation of the comp	l3/20 revealed: er-generated entry for dministered daily at 8:00am. mented as administered 08/09/20. In documented on the eMAR in the electronic progress with the pharmacist at the marmacy on 08/17/20 at rin 81mg were dispensed for //20. Aspirin 81mg were Int #5 on 07/01/20 and on ent #5's medications ration on 08/13/20 at lack of thirty-one Aspirin computer-generated lined to the blister pack and	D 358		
	-The label had a dispe	ense date of 07/31/20.			
	-The date the medication from the blister pack was started was 08/10/20There were twenty-eight tablets remaining in the blister pack.				
	revealed there was ar	#5's FL2 dated 05/22/20 n order for Atorvastatin sed to treat elevated blood y.			
	08/01/20 through 08/ -There was a compute	5's August 2020 eMAR from 13/20 revealed: er-generated entry for be administered daily at			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLE	
					c	;
		HAL060087	B. WING		08/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE SQUARE	5820 CAME				
	OUR MARY OF		TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 54	D 358			
	-There was no reason under "Exceptions" or notes. Telephone interview v facility's contracted pl 2:45pm revealed: -Thirty tablets of Atom dispensed for Reside -Thirty-one tablets of	08/08/20 or 08/09/20. In documented on the eMAR or in the electronic progress with the pharmacist at the harmacy on 08/17/20 at wastatin 10mg were				
	the blister pack and displet daily. -The label had a displet date the medical was started was 08/1. -There were twenty-eleblister pack. m. Review of Resider revealed there was all	ration on 08/13/20 at pack of thirty-one plets with a pharmacy label attached to directions to administer one ense date of 07/31/20. tion from the blister pack				
	Review of Resident # 08/01/20 through 08/ -There was a comput	5's August 2020 eMAR from 13/20 revealed: er-generated entry for administered daily at				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL060087	B. WING		08	C 8/ 17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
CHARLO	ITE SQUARE		MEL ROAD			
		CHARLO	OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pag	e 55	D 358			
	-There was no reaso	s not documented as n 08/08/20 or 08/09/20. n documented on the eMAR or in the electronic progress				
	facility's contracted p 2:45pm revealed: -Thirty tablets of Myr for Resident #5 on 0 -Thirty-one tablets of	with the pharmacist at the charmacy on 08/17/20 at betriq 50mg were dispensed 6/01/20. Myrbetriq 50mg were ent #5 on 07/01/20 and on				
	available for adminis 12:05pm revealed: -There was a blister 50mg tablets with a compharmacy label attack directions to adminis -The label had a disp -The date the medical was started was 08/1	thed to the blister pack and ter one tablet daily. Dense date of 07/31/20. Sation from the blister pack				
	revealed there was a	nt #5's FL2 dated 05/22/20 in order for Cranberry with ly, a vitamin supplement c health.				
	08/01/20 through 08/ -There was a compu Cranberry with vitam at 8:00am. -Cranberry with vitan	#5's August 2020 eMAR from 13/20 revealed: ter-generated entry for in C to be administered daily hin C was not documented on 08/08/20 or 08/09/20.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL060087	B. WING		08	C 3/ 17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CHARLO [*]	ITE SQUARE		MEL ROAD			
	T		OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pag	e 56	D 358			
		n documented on the eMAR r in the electronic progress				
	facility's contracted p 2:45pm revealed: -Thirty tablets of Craidispensed for Reside -Thirty-one tablets of	with the pharmacist at the harmacy on 08/17/20 at herry with vitamin C were ent #5 on 06/01/20. Cranberry with vitamin C Resident #5 on 07/01/20 and				
	available for adminis 12:05pm revealed: -There was a blister with vitamin C tablets pharmacy label attact directions to adminis -The label had a disp -The date the medica was started was 08/1	ense date of 07/31/20. ation from the blister pack				
	revealed there was a	nt #5's FL2 dated 05/22/20 in order for Ocuvite lutein i vitamin supplement used				
	08/01/20 through 08/ -There was a computo Ocuvite lutein capsul daily at 8:00am Ocuvite lutein was a administered daily or -There was no reaso	ter-generated entry for e to be administered once				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL060087	B. WING		C 08/17/2020	
	ROVIDER OR SUPPLIER	STREET AL 5820 CAN	DDRESS, CITY, STA MEL ROAD TTE, NC 28226	TE, ZIP CODE	1 00/1//2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	notes. Telephone interview of facility's contracted pl 2:45pm revealed: -Thirty tablets of Ocur for Resident #5 on 06 -Thirty-one tablets of dispensed for Reside 07/31/20. Observation of Reside available for administ 12:05pm revealed: -There was a blister plutein tablets with a copharmacy label attack directions to administ -The label had a disperthe date the medica was started was 08/1 -There were twenty-eblister pack. p. Review of Residen revealed there was an daily, used as a multivalent Review of Resident #08/01/20 through 08/1-There was a comput Vita-Tab to be adminitationally on 08/08/20 or 08/08/08/20 or 08/08/08/20 or 08/08/08/08/08/08/08/08/08/08/08/08/08/0	with the pharmacist at the narmacy on 08/17/20 at wite lutein were dispensed i/01/20. Ocuvite lutein were nt #5 on 07/01/20 and on ent #5's medications ration on 08/13/20 at eack of thirty-one Ocuvite computer-generated ned to the blister pack and er one tablet daily. ense date of 07/31/20. tion from the blister pack 0/20. ight tablets remaining in the t #5's FL2 dated 05/22/20 n order for Vita-Tab once vitamin supplement. 5's August 2020 eMAR from 13/20 revealed: er-generated entry for a stered daily at 8:00am. umented as administered	D 358			

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facility's contracted pharmacy on 08/17/20 at

STATE FORM 6899 2SZ411 If continuation sheet 58 of 118

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	· ,	SURVEY PLETED	
		HAL060087	B. WING		0.8	C / 17/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE	, 33	
CHARLO	TTE COLLABE	5820 CAI	MEL ROAD			
CHARLO	ITE SQUARE	CHARLO	TTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	dispensed for Reside -Thirty-one tablets of Resident #5 on 07/01 Observation of Reside available for administ 12:05pm revealed: -There was a blister p tablets with a comput	Vita-Tab were dispensed for /20 and on 07/31/20. ent #5's medications				
	-The date the medica was started was 08/1	ense date of 07/31/20. tion from the blister pack 0/20. ight tablets remaining in the				
	chart on 08/13/20 did Medication Incident R	e not offered to Resident #5				
	Attempted telephone 08/12/20 at 9:54am w	interview with a MA on as unsuccessful.				
	Attempted telephone on 08/12/20 at 9:56ar	interview with a second MA n was unsuccessful.				
	Attempted telephone 08/12/20 at 9:57am w	interview with a third MA on as unsuccessful.				
	1	interview with the nurse 8/17/20 at 8:40am was				
		ns, interviews and record nined Resident #5 was not				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		HAL060087	B. WING		08/17/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
CHARLOT	TE SQUARE		MEL ROAD		
	OLIMAN DV OT		TTE, NC 28226	DDOWNERIO DI ANI OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	59	D 358		
	interviewable.				
	Refer to telephone intaide (MA) on 08/10/20	terview with a medication 0 at 1:04pm.			
	Refer to telephone into care aide (PCA) on 0	terview with the personal 8/11/20 at 3:55pm.			
	Refer to telephone interview with another MA on 08/11/20 at 11:20am.				
	Refer to telephone interview with a second MA on 08/12/20 at 10:07am.				
	Refer to telephone int 08/17/20 at 10:23am.	terview with the lead MA on			
		n the pharmacist at the narmacy on 08/17/20 at			
	Refer to interview with Nurse (HWN) on 08/1	n the Health and Wellness 3/20 at 2:30pm.			
	Refer to interview with 08/17/20 at 3:53am.	n the Administrator on			
	11/06/19 revealed dia	t #'3's current FL2 dated gnoses included Alzheimer mia and pre-diabetes.			
		s Variance Report printed Resident #3's medications d on 08/08/20.			
	Order Report dated 0 an order for Oxcarba	t #3's signed Physician 4/20/20 revealed there was zepine, a medication used to 150mg one tablet twice			

daily.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		, , ,	E SURVEY PLETED
7.110 1 27.11	or contraction	ibertii io/tiiot ttombetti	A. BUILDING:			
			B. WING			С
		HAL060087	B. WING		08	3/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CHARLO	TTE SQUARE	5820 CAI	MEL ROAD			
OHARLO	TIE OQUANE	CHARLO	OTTE, NC 28226			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	D 358 Continued From page 60		D 358			
	08/01/20 through 08/ -There was a comput Oxcarbazepine 150m be administered at 8: -Oxcarbazepine was administered on 08/0 -There was no reason under "Exceptions" on notes. Telephone interview of facility's contracted po 2:45pm revealed: -Two blister packs of Oxcarbazepine 150m dispensed for Reside -Two blister packs of Oxcarbazepine 150m	der-generated entry for any twice daily, scheduled to 00am and 8:00pm. In the documented as 8/20 at 8:00am or 8:00pm. In documented on the eMAR or in the electronic progress with the pharmacist at the harmacy on 08/17/20 at thirty tablets of any one tablet twice daily were ont #3 on 06/01/20.				
	Oxcarbazepine with a pharmacy label attack directions to administ morning. -There was a blister poxcarbazepine with a pharmacy label attack directions to administ evening. -The labels for both b date of 07/31/20.	praction on 08/13/20 at pack of thirty-one tablets of a computer-generated hed to the blister pack and pack of thirty-one tablets of a computer-generated hed to the blister pack and per one tablet daily in the pack of the blister pack and per one tablet daily in the packs had a dispense attion from the blister pack				

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PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CHARLOTTE SQUARE S820 CAMEL ROAD CHARLOTTE, NC 28226 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING CHARLOTTE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE S820 CAMEL ROAD CHARLOTTE, NC 28226 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPANDED TO THE APPROPRIATE DATE OF THE APPROPRIA				A. BUILDING: _			
CHARLOTTE SQUARE 5820 CAMEL ROAD CHARLOTTE, NC 28226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANDED TO THE APPROPRIATE DATE OF CROSS-REFERENCED TO THE APPROPR			HAL060087 B. WING				020
CHARLOTTE, NC 28226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANDED TO THE APPROPRIATE DATE: TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CHARLOTTE, NC 28226 ID PROVIDER'S PLAN OF CORRECTION (X COMPANDED TO THE APPROPRIATE DATE)	NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPAND TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DA	CHARLOTTE SQUARE						
	PREFIX	(4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE C	(X5) OMPLETE DATE
There were twenty-seven tablets remaining in the Oxcarbazepine morning blister pack. -There were twenty-eight tablets remaining in the Oxcarbazepine evening blister pack. b. Review of Resident #3's signed Physician Order Report dated 04/20/20 revealed there was an order for Quetiapine 25mg, an anti-psychotic medication used to treat bipolar disorder and depression, once daily at bedtime. Review of Resident #3's August 2020 eMAR from 08/01/20 through 08/13/20 revealed: -There was a computer-generated entry for Quetiapine 25mg at bedtime, scheduled to be administered daily at 8:00pm. -Quetiapine was not documented as administered on 08/08/20. -There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes. Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed: -A blister pack of thirty tablets of Quetiapine 25mg daily at bedtime were dispensed for Resident #3 on 06/01/20. A blister pack of thirty-one tablets of Quetiapine 25mg daily at bedtime were dispensed for Resident #3 on 07/01/20 and on 07/31/20. Observation of Resident #3's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a blister pack of thirty-one tablets of Quetiapine was allister pack and directions to administer one tablet daily in the evening.	D 358	-There were twenty-s the Oxcarbazepine m -There were twenty-e Oxcarbazepine eveni b. Review of Residen Order Report dated 0 an order for Quetiapin medication used to tr depression, once dail Review of Resident # 08/01/20 through 08/ -There was a comput Quetiapine 25mg at b administered daily at -Quetiapine was no reason under "Exceptions" o notes. Telephone interview of facility's contracted p 2:45pm revealed: -A blister pack of thirt daily at bedtime were on 06/01/20A blister pack of thirt daily at bedtime Resident #3 on 07/01 Observation of Resid available for administ 12:05pm revealed: -There was a blister p Quetiapine with a cor label attached to the	even tablets remaining in forning blister pack. sight tablets remaining in the ng blister pack. It #3's signed Physician 14/20/20 revealed there was ne 25mg, an anti-psychotic eat bipolar disorder and y at bedtime. 13's August 2020 eMAR from 13/20 revealed: er-generated entry for bedtime, scheduled to be 8:00pm. 13'cocumented as administered and documented as administered and documented on the eMAR or in the electronic progress. 14's August 2020 eMAR from 13/20 revealed: er-generated entry for bedtime, scheduled to be 8:00pm. 15'cocumented on the eMAR or in the electronic progress. 16'cocumented on the eMAR or in the electronic progress. 17'cocumented on the emain at the electronic progress. 18'cocumented on the emain at the electronic progress. 19'cocumented on 08/17/20 at 19'cocumented on 08/13/20 at 19'cocumented on 07/31/20. 19'cocumented on 07/31/20 at 19'cocumented on 08/13/20 at 19'c	D 358	DEL NOILING I)		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060087	B. WING		C 08/17/2020
					06/17/2020
NAME OF P	ROVIDER OR SUPPLIER	5820 CAM	DRESS, CITY, STA	TE, ZIP CODE	
CHARLO1	TE SQUARE		TE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 358	was started was 08/10-There were twenty-equetiapine blister pace. C. Review of Resident Order Report dated refor Sertraline 50mg, adepression, once dail Review of Resident # 08/01/20 through 08/10-There was a compute Sertraline 50mg once 8:00amSertraline was not do on 08/08/20There was no reason under "Exceptions" or notes. Telephone interview of facility's contracted pt 2:45pm revealed: -A blister pack of thirty daily at bedtime were on 06/01/20A blister pack of thirty 50mg daily at bedtime Resident #3 on 07/01 Attempted telephone practitioner (NP) on 0 unsuccessful.	tion from the blister pack 0/20. ight tablets remaining in the ck. It #3's signed Physician evealed there was an order medication used to treat y. 3's August 2020 eMAR from 13/20 revealed: er-generated entry for daily to be administered at ocumented as administered in documented on the eMAR of the electronic progress with the pharmacist at the narmacy on 08/17/20 at y tablets of Sertraline evere dispensed for Resident #3 y-one tablets of Sertraline evere dispensed for /20 and on 07/31/20. interview with the nurse 8/17/20 at 8:40am was	D 358		
		nined Resident #3 was not			

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					c	
		HAL060087	B. WING		08/17/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
			MEL ROAD	,		
CHARLOT	TE SQUARE		TTE, NC 28226			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	
D 358	Continued From page 63		D 358			
	Refer to telephone interview with a medication aide (MA) on 08/10/20 at 1:04pm.					
	D-f	4				
	care aide (PCA) on 0	terview with the personal				
	care aide (i CA) on o	ο/ 11/20 at 3.33μm.				
	Refer to telephone in	terview with another MA on				
	08/11/20 at 11:20am.					
	Refer to telephone interview with a second MA on					
	08/12/20 at 10:07am.					
	Refer to telephone in	terview with the lead MA on				
	08/17/20 at 10:23am.					
		h the pharmacist at the				
	2:45pm.	harmacy on 08/17/20 at				
	2.40pm.					
	Refer to interview with	h the Health and Wellness				
	Nurse (HWN) on 08/1	13/20 at 2:30pm.				
	Refer to interview with 08/17/20 at 3:53am.	h the Administrator on				
	00/17/20 at 3.33aiii.					
	-	it #4's current FL2 dated				
		agnoses included dementia,				
	hypertension, diabete	ss, and depression.				
	Review of the facility's	s variance report printed				
		Resident #4's medications				
	were not administered	d on 08/08/20.				
	a. Review of Residen 04/28/20 revealed the	t #4's current FL2 dated				
		ere was an orger for epression) 40mg one tablet				
	daily.	oprossion, tomy one lablet				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL060087	B. WING		C 08/17/2020	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 00	
CHAPI OT	TE SQUARE	5820 CAMI	EL ROAD			
CHARLO	TE SQUARE	CHARLOT	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COM	K5) PLETE ATE
D 358	Continued From page	e 64	D 358			
	medication administra 08/01/20-08/13/20 rev -There was a comput Citalopram 40mg one administered daily at -Citalopram was not of at 8:00am on 08/08/2 -There was no reason under "exceptions" or notes. Observation of Residuavailable for administra 12:05pm revealed: -There was a blister prablets with a comput label attached and the tablet once daily with 08/10/20.	er-generated entry for tablet daily to be 8:00am. documented as administered 0. n documented on the eMAR in the electronic progress ent #4's medications ration on 08/13/20 at eack of Citalopram 40mg er-generated pharmacy e directions to administer 1				
	04/28/20 revealed the	t #4's current FL2 dated ere was an order for mentia) 10mg one tablet				
	medication administra 08/01/20-08/13/20 rev -There was a compute Donepezil 10mg one administered daily at -Donepezil was not dat 8:00am on 08/08/2 -There was no reason	er-generated entry for tablet daily to be 8:00am. ocumented as administered				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMP	LETED
		HAL060087	B. WING		08.	C / 17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STAT	E, ZIP CODE		
CHARLOT	TE SQUARE		MEL ROAD TTE, NC 28226			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 358	Continued From page	e 65	D 358			
	Observation of Residavailable for administ 12:05pm revealed: -There was a blister pablets with a comput label attached and thablet once daily with 08/10/20There were 28 table pack. c. Review of Resident 46 Gabapentin (to treat capsule at bedtime. Review of Resident 47 medication administration administration of Resident 48 capsule at bedtime. Review of Resident 47 medication administration administration of Residapentin 300mg of Gabapentin was not administered at 8:00procession of Residavailable for administration of	ent #4's medications ration on 08/13/20 at pack of Donepezil 10mg per-generated pharmacy red directions to administer 1 a dispense date of a dispense date of ts remaining in the blister at #4's current FL2 dated red was an order for rerve pain) 300mg one at sugust 2020 electronic red tion record (eMAR) from realed: red generated entry for red capsule at 8:00pm. documented as red on 08/08/20. In documented on the eMAR r in the electronic progress real #4's medications reation on 08/13/20 at pack of gabapentin capsules reated pharmacy label rections to administer 1 tablet				
	-There were 28 table pack. d. Review of Residen 04/28/20 revealed the	ts remaining in the blister at #4's current FL2 dated ere was an order for in) 200mg two tablets twice				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060087	B. WING	 	08	C 8/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE	·	
CHARLO	TTE COLLABE	5820 CA	MEL ROAD			
CHARLO	ITE SQUARE	CHARLO	OTTE, NC 28226			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	daily. Review of Resident # medication administra 08/01/20-08/13/20 rev-There was a comput lbuprofen 200mg two administered at 8:00a-lbuprofen was not do at 8:00am and 8:00pr-There was no reason under "exceptions" or notes. Observation of Reside available for administ 12:05pm revealed: -There was a blister ptablets with a comput label attached and the tablets at 8:00am and 08/10/20There was a blister ptablets with a comput label attached and the tablets at 8:00pm and 08/10/20There was a blister ptablets with a comput label attached and the tablets at 8:00pm and 08/10/20There were 56 tablet pack. e. Review of Residen 04/28/20 revealed the	4's August 2020 electronic ation record (eMAR) from vealed: er-generated entry for tablets twice daily to be am and 8:00pm. In the electronic progress artion on 08/08/20. In the electronic progress artion on 08/13/20 at the electronic progress articles are electronic progress articles articles articles articles articles are electronic progress articles articles articles articles articles are electronic progress articles arti	D 358	DEFICIENC!)		
	Levemir 30units every Review of Resident #	4's August 2020 electronic ation record (eMAR) from				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			0
		HAL060087	B. WING		08	C 8/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	. ZIP CODE	•	
			MEL ROAD	,		
CHARLO	ITE SQUARE		OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
D 358	Levemir 40 units every levemir 40 units was administered at 8:00a levemir 30 units every levemir 30 units was administered at 8:00p levemir 30 units was administered at 8:00p levemir 30 units was administered at 8:00p levemir 30 units every levemir 30 units every levemir 30 units every levemir or notes. Observation of Resid available for administ 12:05pm revealed: levemir is computer-generated and the directions to morning and 30 units date of 07/17/20 with f. On Resident #4's continuity of there was an order for insulin) 100u/ml 12un meals, hold if finger so (FSBS) is 60. Review of Resident #medication administration administration of the properties	er-generated entry for ry morning at 8:00am. In some some of the solution of t	D 358	DEFICIENCY		
	8:00am, 12:00pm, an -There was no reason	was not documented at d 5:00pm on 08/08/20. In documented on the eMAR in the electronic progress				

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DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
					l c	
		HAL060087	B. WING		08/17/2020	
		HALU00007			1 00/1/	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		5820 CAI	MEL ROAD			
CHARLOT	TE SQUARE	CHARLO	TTE, NC 28226			
0.0	CLIMMA DV CT			DROVIDER'S DIANIOS CORRECTION	<u> </u>	0.5
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D 250	0 " 15	00	D 250			
D 358	Continued From page	9 68	D 358			
	notes.					
	-On 08/10/20 at 8:00a	am Resident #4's FSBS was				
	187, and no Novolog					
	,	nted on the eMAR under				
		0/20 at 9:16am as waiting on				
	refills.	720 at 0. roam at watting on				
		Dpm Resident #4's FSBS				
		olog was administered.				
	· ·	nted on the eMAR under				
		0/20 at 11:56am as waiting				
	on refills.	7720 at 11.00am as waiting				
		om Resident #4's FSBS was				
	177, and no Novolog					
		nted on the eMAR under				
		0/20 at 4:44pm as waiting on				
	refills.	720 at 4.44pm as waiting on				
		am Resident #4's FSBS was				
	131, and no Novolog					
		nted on the eMAR under				
		1/20 at 7:56am as waiting on				
	refills.	1/20 at 7:30am as waiting on				
		pm Resident #4's FSBS				
		olog was administered.				
	· ·	nted on the eMAR under				
		1/20 at 11:56am as waiting				
	on refills.	1/20 at 11.50aill as waiting				
		om Resident #4's FSBS was				
	not documented, and					
	administered.	no novolog was				
		nted on the eMAR under				
	refills.	1/20 at 4:35pm as waiting on				
		am Resident #4's FSBS was				
	134, and no Novolog					
		was administered. nted on the eMAR under				
	-	2/20 at 8:21am as waiting on				
	refills.	Dom Booldont #4!- FCBC				
		Dam Resident #4's FSBS				
		olog was administered.				
	- i ne reason documer	nted on the eMAR under				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060087	B. WING		08	C 3/ 17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
		5820 CA	MEL ROAD			
CHARLO	TTE SQUARE	CHARLO	OTTE, NC 28226			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENT TAG CROSS-		PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 358	D 358 Continued From page 69		D 358			
	on refillsOn 08/12/20 at 5:00p 203, and Novolog 120 -Resident #4 missed FSBS on 08/08/20Resident #4 missed 08/10/20 to 08/12/20 08/11/20 at 5:00pmResident #4 FSBS ra 08/01/20-08/13/20 wa to 256 on 08/09/20 at Observation of Residavailable for administ 12:05pm revealed: -There was Novolog of computer-generated pand the directions to a times daily with meals	as 92 on 08/07/20 at 5:00pm 5:00pm. ent #4's medications				
	08/17/20 at 3:53pm re-On 08/13/20 when si missed doses of her i medication aide (MA) administering it. -The MA informed he available to administering it. -The MA failed to noti another vial for delive. -The MA was responsive refills from the pharm excuse it wasn't reord resident #4's insulin the MA using the eMA pharmacy.	ne was notified Resident #4 Novolog she went to the responsible for not r that the Novolog was not er it. fy the pharmacy to obtain ry. sible for reordering all insulin acy, and there was no dered. should have been order by AR system from the				
		e being printing weekly by				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 20122			С
		HAL060087	B. WING			/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE ZIP CODE		
	10115211 011 001 1 21211		MEL ROAD			
CHARLOT	TE SQUARE		OTTE, NC 28226			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETE DATE
D 358	Continued From page 70		D 358			
	the Health & Wellness	s Nurse (HWN) until she				
	recently became busy					
	-	d to SCU residents after the				
	previous Special Care	e Coordinator (SCC)				
	resigned.					
		ts were to be completed				
	Resident #4 was in th	time one was completed for				
	Nesident #4 was in th	ie beginning or July.				
	g. Review of Residen	t #4's current FL2 dated				
	04/28/20 revealed there was an order for Quetiapine (to treat depression) 25mg one tablet					
	twice daily.					
	Review of Resident #	4's August 2020 electronic				
		ation record (eMAR) from				
	08/01/20-08/13/20 rev	vealed:				
		er-generated entry for				
		tablet twice daily to be				
	administered at 8:00a	documented as administered				
	at 8:00am and 8:00pr					
		n documented on the eMAR				
	under "exceptions" or	in the electronic progress				
	notes.					
	Observation of Reside	ent #4's medications				
	available for administ					
	12:05pm revealed:					
	-There was a blister p	pack of Quetiapine 25mg				
		er-generated pharmacy				
		e directions to administer 1				
		a dispense date of 08/10/20.				
		s remaining in the blister				
	packThere was a blister n	pack of Quetiapine 25mg				
		er-generated pharmacy				
	-	e directions to administer 1				
		a dispense date of 08/10/20.				
	-	s remaining in the blister				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		HAL060087	B. WING		08/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE	-
TO UNIC OT T	NOVIBER OR GOLF EIER		IEL ROAD	, 2.11 0002	
CHARLOTTE SQUARE			TTE, NC 28226		
0// 15	STIMMADV ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	d over
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 71	D 358		
	pack.				
	Attempted telephone interview with the nurse practitioner (NP) on 08/17/20 at 8:40am was unsuccessful.				
		ns, interviews and record mined Resident #4 was not			
	Refer to telephone interview with a medication aide (MA) on 08/10/20 at 1:04pm.				
	Refer to telephone into care aide (PCA) on 0	terview with the personal 8/11/20 at 3:55pm.			
	Refer to telephone int 08/11/20 at 11:20am.	terview with another MA on			
	Refer to telephone into 08/12/20 at 10:07am.	terview with a second MA on			
	Refer to telephone into 08/17/20 at 10:23am.	terview with the lead MA on			
		h the pharmacist at the harmacy on 08/17/20 at			
	Refer to interview with Nurse (HWN) on 08/1	h the Health and Wellness 13/20 at 2:30pm.			
	Refer to interview witl 08/17/20 at 3:53am.	h the Administrator on			
		t #2's current FL2 dated agnoses included dementia, scle weakness, and			

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Division of Health Service Regulation

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		HAL060087	B. WING		1	
		HALU60007			1 00/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		5820 CAN	IEL ROAD			
CHARLOT	TE SQUARE	CHARLO	TTE, NC 28226			
	OLUMANA DV OT			DDOVIDEDIO DI ANI OE CODDECTIO		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 250	0	- 70	D 358			
D 358	Continued From page	e 72	D 336			
	Review of the facility's	s variance report printed				
	-	Resident #2's medications				
	were not administered	d on 08/08/20.				
	a. Review of Residen	t #2's current FL2 dated				
	06/15/20 revealed the	ere was an order for Vitamin				
	D3 (to treat vitamin D	deficiency) 1000iu one				
	tablet daily.	3 ,				
	,					
	Review of Resident #	2's August 2020 electronic				
		ation record (eMAR) from				
	08/01/20-08/13/20 rev	` ,				
		er-generated entry for				
	Vitamin D3 1000iu on					
	administered daily at	•				
	-Vitamin D3 was not o					
	administered at 8:00a					
		n documented on the eMAR				
		in the electronic progress				
	notes.	in the discitoring progress				
	110100.					
	Observation of Residen	ent #2's medications				
	available for administ					
		ere was a bottle of Vitamin				
	•	psules and the directions to				
		•				
	administer 1 tablet on	ice daily.				
	h Daview of Deciden	t #01				
		t #2's current FL2 dated				
	06/15/20 revealed the					
		to treat hypertension) 25mg				
	one tablet daily.					
	Daview of Decide 11	601a A				
		2's August 2020 electronic				
		ation record (eMAR) from				
	08/01/20-08/13/20 rev					
	-	er-generated entry for				
	•	5mg one tablet daily at				
	8:00am.					
		was not documented as				
	administered at 8:00a	am on 08/08/20.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or doring of the state of the s	IDENTIFICATION NOMBER.	A. BUILDING: _			
		HAL060087	B. WING		08/17/2	2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	•	
CHARLO	TE SQUARE	5820 CAM	EL ROAD			
CHARLO	TE SQUARE	CHARLOT	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 73	D 358			
	-There was no reasor	n documented on the eMAR in the electronic progress				
	25mg tablets with a compharmacy label attack administer 1 tablet on date of 08/10/20.	ration on 08/13/20 at pack of hydrochlorothiazide				
	06/15/20 revealed the	t #2's current FL2 dated ere was an order for t hypothyroidism) 50mcg				
	medication administra 08/01/20-08/13/20 rev -There was a comput levothyroxine 50mcg -Levothyroxine was n administered at 8:00a -There was no reason	er-generated entry for one tablet daily at 8:00am. ot documented as				
	tablets with a comput label attached and the tablet once daily and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	DNSTRUCTION		E SURVEY PLETED	
		HAL060087	B. WING		08	C 8/ 17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
CHARLOT	TE SQUARE		MEL ROAD			
	· 		OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pag	e 74	D 358			
	06/15/20 revealed th	nt #2's current FL2 dated ere was an order for depression) 15mg one tablet				
	medication administr 08/01/20-08/13/20 re -There was a compu mirtazapine 15mg or -Levothyroxine was r	ter-generated entry for ne tablet daily at 8:00am. not documented as				
		am on 08/08/20. In documented on the eMAR In the electronic progress				
	available for adminis 12:05pm revealed: -There was a blister tablets with a compulabel attached and the tablet once daily and	dent #2's medications tration on 08/13/20 at pack of mirtazapine 15mg ter-generated pharmacy ne directions to administer 1 la dispense date of 08/10/20.				
	e. Review of Resider 06/15/20 revealed th	nt #2's current FL2 dated ere was an order for heartburn) 20mg one tablet				
	medication administr 08/01/20-08/13/20 re -There was a compu	ter-generated entry for ne tablet daily at 8:00am. not documented as				

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DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		HAL 000007	B. WING			
		HAL060087			08/1	7/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		5820 CAI	MEL ROAD			
CHARLOT	TE SQUARE		TTE, NC 28226			
			112, 110 20220			1
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
			 			
D 358	Continued From page	e 75	D 358			
	under "exceptions" or	in the electronic progress				
	notes.	in the diseasonie progress				
	110100.					
	Observation of Residen	ent #2's medications				
	available for administ					
	12:05pm revealed:	14tion on 00/10/20 at				
	-	pack of omeprazole 20mg				
		er-generated pharmacy				
	•	e directions to administer 1				
		a dispense date of 08/10/20.				
	_					
		s remaining in the blister				
	pack.					
	Attempted telephone	interview with the nurse				
		8/17/20 at 8:40am was				
	unsuccessful.	10/11/20 at 6.40aiii was				
	unsuccessiui.					
	Paged on absorvation	ns, interviews and record				
		nined Resident #2 was not				
	·	nined Resident #2 was not				
	interviewable.					
	Defeate telembers int	hamiau vikla a maadiaakian				
		terview with a medication				
	aide (MA) on 08/10/2	u at 1:04pm.				
	Defends delember sind					
	·	terview with the personal				
	care aide (PCA) on 0	8/11/20 at 3:55pm.				
	D () () ()					
		terview with another MA on				
	08/11/20 at 11:20am.					
	Defends talenteen 11	Lamiano vidla a a a a a a d BAA a				
	•	terview with a second MA on				
	08/12/20 at 10:07am.					
	Defenda tal 1					
		terview with the lead MA on				
	08/17/20 at 10:23am.					
		h the pharmacist at the				
	*	harmacy on 08/17/20 at				
	2:45pm.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMILETED
		HAL060087	B. WING		C 08/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CHARLO1	TE SQUARE	5820 CAN			
			TTE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE
D 358	Continued From page	e 76	D 358		
	Refer to interview wit Nurse (HWN) on 08/1	h the Health and Wellness 13/20 at 2:30pm.			
	Refer to interview wit 08/17/20 at 3:53am.	h the Administrator on			
	11/12/19 revealed dia	nt #'6's current FL2 dated agnoses included dementia, calorie malnutrition, and			
	08/13/20 revealed all	s variance report printed on of Resident #6's morning administered on 08/09/20.			
	dated 03/05/20 revea patch 5% (to treat mu	nt #6's physician's order aled an order for a Lidoderm ascle pain), apply one patch o low back and remove after			
	medication administra 08/01/20-08/13/20 re -There was a comput	f6's August 2020 electronic ation record (eMAR) from vealed: er-generated entry for oply one patch daily and			
	remove after 12 hour- -Lidocaine Pad was r administered at 8:00a -There was no reason under "exceptions" or	s. not documented as			
	notes.				
	pads 5% with a complabel attached and the				

Division of Health Service Regulation

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HAL060087 HAL060087 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5820 CAMEL ROAD CHARLOTTE SQUARE CHARLOTTE, NC 28226 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO T	CORRECTION ION SHOULD BE HE APPROPRIATE	C /17/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5820 CAMEL ROAD CHARLOTTE SQUARE (X4) ID PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL CEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CEACH CORRECTIVE ACT	CORRECTION ION SHOULD BE HE APPROPRIATE	_
CHARLOTTE SQUARE 5820 CAMEL ROAD CHARLOTTE, NC 28226 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT	ION SHOULD BE HE APPROPRIATE	
CHARLOTTE SQUARE CHARLOTTE, NC 28226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT	ION SHOULD BE HE APPROPRIATE	
CHARLOTTE, NC 28226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT	ION SHOULD BE HE APPROPRIATE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT	ION SHOULD BE HE APPROPRIATE	
DEFICIENCE	-,	(X5) COMPLETE DATE
D 358 Continued From page 77 D 358		
b. Review of Resident #6's physician's order dated 02/07/20 revealed an order for lorazepam 0.5mg (to treat anxiety), take one tablet by mouth four times daily.		
Review of Resident #6's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for lorazepam 0.5mg, take one tablet by mouth four		
times dailyLorazepam was not documented as administered at 8:00am on 08/09/20There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes.		
Observation of Resident #6's medications available for administration on 08/13/20 at 12:00pm revealed: -There was a blister pack of lorazepam 0.5mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth four times daily and a dispense date of 07/01/20There were 35 of 62 tablets remaining in the blister pack.		
c. Review of Resident #6's physician's order dated 02/07/20 revealed an order for losartan 25mg (to treat high blood pressure), take one tablet by mouth daily.		
Review of Resident #6's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for losartan 25mg, take one tablet by mouth dailyLosartan was not documented as administered		

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					_	
			D WING		c	
		HAL060087	B. WING		08/1	7/2020
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			IEL ROAD	,		
CHARLOT	TE SQUARE					
		CHARLO	TTE, NC 28226			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	NEGOLATORT OR L	ESCIDENTIF TING IN CHIMATION)	TAG	DEFICIENCY)	MAIL	5,112
D 358	Continued From page	e 78	D 358			
	at 0.00am an 00/00/0	0				
	at 8:00am on 08/09/2					
		n documented on the eMAR				
	under "exceptions" or	in the electronic progress				
	notes.					
	Observation of Reside					
	available for administ	ration on 08/13/20 at				
	12:00pm revealed:					
		ack of losartan 25mg with a				
	computer-generated	pharmacy label attached				
	and the directions to t	take one tablet by mouth				
	daily and a dispense	date of 08/10/20.				
	-There were 27 tablet	s remaining in the blister				
	pack.	•				
	-There was a second	blister pack of losartan				
		r-generated pharmacy label				
		ctions to take one tablet by				
		pense date of 08/10/20.				
		s remaining in the blister				
	pack.	is remaining in the blister				
	раск.					
	d Review of Residen	t #6's physician's order				
		led an order for metoprolol				
		•				
		ood pressure), take one				
	tablet by mouth twice	dally.				
	Davious of Dasidant #	S'o August 2020 alastrania				
		6's August 2020 electronic				
		ation record (eMAR) from				
	08/01/20-08/13/20 rev					
		er-generated entry for				
	metoprolol 25mg, take daily.	e one tablet by mouth twice				
	-Metoprolol 25mg was	s not documented as				
	administered at 8:00a	am on 08/09/20.				
	-There was no reasor	n documented on the eMAR				
	under "exceptions" or	in the electronic progress				
	notes.	1 3				
	Observation of Reside	ent #6's medications				

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available for administration on 08/13/20 at

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DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						,
		HAL060087	B. WING		1	
		HALUUUU07			06/1	17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
		5820 CAI	MEL ROAD			
CHARLOT	TE SQUARE	CHARLO	TTE, NC 28226			
040.15	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION)N	0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	PRIATE	DATE
				DEFICIENCY)		
D 358	Continued From page	e 79	D 358			
	12:00pm revealed:					
	-	pack of metoprolol 25mg				
		erated pharmacy label				
		ctions to take one tablet by				
	mouth twice daily and					
	08/10/20.	a disperise date of				
		ts remaining in the blister				
	pack.	to romaning in the bileter				
	•	blister pack of metoprolol				
		er-generated pharmacy label				
		ctions to take one tablet by				
	mouth twice daily and					
	08/10/20.	a disperise date of				
		ts remaining in the blister				
	pack.	is remaining in the blister				
	раск.					
	Interview with the He	alth & Wellness Nurse				
		t 2:30pm revealed she was				
	not aware that Reside					
		administered on 08/09/20.				
	medications were not	administered on 00/09/20.				
	Attempted telephone	interview with Resident #6's				
		PA) on 08/17/20 at 9:00am				
	was unsuccessful.	A) 011 00/11/20 at 3.00aiii				
	was unsuccessiui.					
	Attempted interview w	vith Resident #6 on 08/13/20				
	at 2:10pm was unsuc					
	at 2. ropin was unsuc	ocasiui.				
	Refer to telephone int	terview with medication aide				
	(MA) on 08/11/20 at 1					
	(1711 t) OII OO! 11/20 at 1	11.20am.				
	Refer to interview with	h the HWD on 08/13/20 at				
	2:30pm.	11 415 11445 311 00/ 13/20 at				
	2.30μπ.					
	Refer to telephone int	terview with the lead MA on				
	08/17/20 at 10:23am.					
	00/11/20 at 10.20aiii.					
	Refer to interview with	h the Administrator on				
	08/17/20 at 3:53pm.	a.o / tariminotiator on				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL060087	B. WING		0.6	C 3/17/2020
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE	1 00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
			MEL ROAD	, 211 0052		
CHARLO	TTE SQUARE		OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	6. Review of Residen 05/29/20 revealed dia renal disease, diabete depression, hyperten Review of the facility's 08/13/20 revealed all medications were not a. Review of Residen 05/29/20 revealed the for morphine sulfate 3 take one tablet by more revealed: -There was a comput morphine sulfate 30m three times daily at 10 10:00pm. -Morphine sulfate was administered on 7/25/9:41pm, 07/27/20 at 12:41pm, 07/27/20 at 12:41pm, 07/27/20 at 10:32am, and 07/28/2-The reason documer "exceptions" was "wa-There was no documer "exceptions" was "wa-There was no documer medication being una Review of Resident #from July 2020 revea -A written entry dated been demanding narroresident continuously demanding that he get	at #'7's current FL2 dated agnoses included end stage es mellitus type 2, sion, and anemia. s variance report printed on of Resident #7's morning and administered on 08/08/20. It #'7's current FL2 dated ere was a physician's order 30mg (to treat severe pain), buth three times daily. It you want to be a solution of the series of the s	D 358			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
						С
		HAL060087	B. WING		30	3/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATI	E, ZIP CODE		
CHARLO	ITE SQUARE	5820 CAN	IEL ROAD			
CHARLO	TIE SQUARE	CHARLO	TTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 81	D 358			
	about his medicationA written entry dated his medication to be of a compart of the physician had lead to the physician	07/29/20 "Resident ask for doubled." nentation that the pharmacy been called. 7's August 2020 electronic ation record (eMAR) from wealed: er-generated entry for ng, take one tablet by mouth 0:00am, 2:00pm, and				
	30mg tablets with a compharmacy label attack take one tablet by modispense date of 07/2-There were 8 of 45 tablister packThere was a second sulfate 30mg tablets with pharmacy label attack take one tablet by modispense date of 08/0	praction on 08/13/20 at each of morphine sulfate computer-generated end and the directions to buth three times daily and a 28/20. Ablets remaining in the elister pack of morphine with a computer-generated end and the directions to buth three times daily and a				
	Telephone interview v	vith the Pharmacist from the				

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DIVISION	or riealth Service Negu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_		
			D 14/11/0		C
		HAL060087	B. WING		08/17/2020
NAME OF D	DOVIDED OD SUDDUED	STREET AD	DRESS, CITY, STA	TE 710 CODE	
NAIVIE OF P	ROVIDER OR SUPPLIER			II E, ZIP GODE	
CHARLOT	TE SQUARE	5820 CAM			
		CHARLOT	TE, NC 28226		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				DEI ICIENCI)	
D 358	Continued From page	82	D 358		
		narmacy on 08/14/20 at			
	2:23pm revealed:				
	-The pharmacy was re	esponsible for dispensing			
	Resident #7's morphi	ne sulfate.			
	-The pharmacy had d	ispensed a 15-day supply of			
	morphine sulfate 30m	ig, take one tablet three			
	times daily to Resider	nt #7 on 07/28/20 and			
	08/07/20.				
	Telephone interview v	vith Resident #7's Hospice			
	•	:20pm and 8/17/20 at			
	1:07pm revealed:	op aa o,, _o a.			
	•	working with the resident on			
	07/27/20.	Working With the resident on			
		s controlled medications on			
	07/27/20.	controlled medications on			
		hat he ran out of marphine			
		hat he ran out of morphine			
	sulfate in July 2020.	literate manifestation and form			
		lity to review the need for			
	refills on controlled su	ibstances for nospice			
	patients.				
	-If refills or prescriptio				
		s, she would contact the			
	hospice physician.				
		vith the Health and Wellness			
	, ,	7/20 at 10:04am revealed:			
	-The facility had requi	ested Resident #7's			
	morphine be filled bef	fore the resident ran out in			
	July 2020.				
	-Hospice was suppos	ed to get the prescription for			
	morphine sulfate from	the physician but did not			
	due to Hospice nurse	being out sick.			
		getting the prescription			
	directly from the phys				
		in mid-July and was not			
	aware the medication				
	Telephone interview v	vith a first shift medication			

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aide (MA) on 08/17/20 at 2:02pm revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					l c
		HAL060087	B. WING		08/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE	
		5820 CAM		,	
CHARLO1	TE SQUARE		TE, NC 28226		
			1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 83	D 358		
	-The pharmacy did not Resident #7 like they 2020Hospice was suppose in mid-July to the pharmacy received itA second prescription that it why it was not a construction was aware that doses on the days that medication was unaverwhen medications of the MA is responsible pharmacy or the physe-Resident #7 did not be behaviors related to a construction of the MA was responsible pharmacy or the physe-Resident #7 did not be behaviors related to a construction of the MA was responsible to the morphine sulfate in July-The MA was responsible pharmacy of the physe-Resident was not aware the morphine sulfate in July-The MA was responsible to the morphine sulfate in July-The MA was responsible to the MA was responsible to the morphine sulfate in July-The MA was responsible to the MA was responsi	ot fill the morphine sulfate for were supposed to in July seed to send the prescription armacy, but the pharmacy in had to be obtained, and filled until 7/28/20. Resident #7 had missed at she worked because the ailable. In onot get delivered on time, of for contacting the sician. In have any increased pain or missed pain medication. With the Administrator on evealed: In hat Resident #7 ran out of culy 2020. Isible to notify the HWN is that were unavailable for the triangle of triangle of the triangle of triangle of the triangle of			
	for hydralazine 50mg pressure), take one ta	ablet by mouth three times			
	daily.				
	medication administrative revealed: -There was a comput hydralazine 50mg, taltimes daily at 9:00am -Hydralazine was door	er-generated entry for ke one tablet by mouth three , 1:00pm, and 9:00pm.			

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at 1:06pm, 07/15/20 at 12:11pm, 7/20/20 at

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _	A. BUILDING:		EIED
		HAL060087	B. WING		00/4	; 7/2020
					00/1	112020
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
CHARLO	TE SQUARE	5820 CAM	EL ROAD TE, NC 28226			
0/0.15	STIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 358	Continued From page	e 84	D 358			
	1:18pm, 07/21/20 at 107/27/20 at 12:41pm, -The reason documer "exceptions" was "wa -There was no documer or physician had beer medication being una -Hydralazine was not administered at 1:00p was no reason docum "exceptions" or in the Review of Resident # 08/01/20-08/13/20 rev -There was a comput hydralazine 50mg, tal times daily at 9:00am -Hydralazine was not administered at 9:00a 1:00pm on 08/09/20There was no reason	1:00pm, 07/22/20 at 1:36pm, and 07/28/20 at 12:54pm. Inted on the eMAR under iting on refills from MD". Inentation that the pharmacy in contacted regarding the vailable. Independent of the emandary of the				
	with a computer-gene attached and the dire mouth three times da	ration on 08/13/20 at back of hydralazine 50mg				
	packThere was a blister p with a computer-gene attached and the dire mouth three times da 08/10/20.	es remaining in the blister back of hydralazine 50mg brated pharmacy label ctions to take one tablet by ily and a dispense date of s remaining in the blister				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:	A. BUILDING:		LETED
		HAL060087	B. WING			C / 17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CHARLOT	TE SQUARE	5820 CA	MEL ROAD			
OHARLO	TE OGOANE	CHARLO	OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 85	D 358			
	packThere was a blister with a computer-generattached and the direct mouth three times day 08/10/20.	pack of hydralazine 50mg erated pharmacy label ections to take one tablet by ally and a dispense date of ts remaining in the blister				
	aide on 08/17/20 at 2 -The pharmacy did n they were supposed -It was on cycle fill ar automatically each m -She was aware that doses at lunch time of because the medicat	ot fill the hydralazine like to in July 2020. Ind should have been filled nonth. The had missed a "few" on days that she worked ion was unavailable. It is not get delivered on time, te for contacting the				
	facility's contracted p 2:16pm revealed: -The pharmacy was a Resident #7's hydrala -The pharmacy had of hydralazine 50mg, ta daily to Resident #7' o 66/10/20, a 31-day s 07/10/20, a 12-day s previous pharmacy's -They dispensed a 3' start 08/10/20 on the -They had switched of system on 08/03/20.	dispensed a 30-day supply of ke one tablet three times on 06/01/20 to start on upply on 07/01/20 to start on upply on 07/28/20 from the computer system. 1-day supply on 07/31/20 to				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060087	B. WING	B. WING		7/2020
	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA EL ROAD TE, NC 28226	TE, ZIP CODE	, 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	1:07pm revealed: -She was not aware to in July 2020She had just started 07/27/20All other medications have to be requested Telephone interview wo 08/17/20 at 4:00pm resolvedShe was not aware to this hydralazine in July -The MA was responsive regarding medications residents. c. Review of Residen 05/29/20 revealed the solution (to treat dry reseconds and spit out the medication administration 08/01/20-08/13/20 resolution administration of the solution was administered at 9:00a -There was no reason under "exceptions" or notes. Observation of Reside the solution of Reside available for administration 12:05pm revealed the solution with a computation of the solution with a computation of the solution with a computation	working with the resident on including hydralazine would by the facility. with the Administrator on evealed: hat Resident #7 ran out of y 2020. Sible to notify the HWN is that were unavailable for it #7s current FL2 dated are was an order for Biotene mouth), swish 15ml for 30 twice daily. 7's August 2020 electronic ation record (eMAR) from yealed: er-generated entry for la, swish 15ml for 30 seconds lay. not documented as lam on 08/08/20. In documented on the eMAR lain the electronic progress ent #7's medications ration on 08/13/20 at lare was a bottle of Biotene later-generated pharmacy and directions to swish 15ml	D 358	DELIGITION 1)		

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AND PLAN OF CORRECTION IDENTIFICATION NUM	IDED.	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
HAL060087	B. WING		C 08/17/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE	E, ZIP CODE	1 00.117.2020
OUADI OTTE COUADE	5820 CAMEL ROAD		
CHARLOTTE SQUARE	CHARLOTTE, NC 28226		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY F TAG REGULATORY OR LSC IDENTIFYING INFORMAT	ULL PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE
d. Review of Resident #'7's current FL2 dat 05/29/20 revealed there was an order for bumetanide (to treat high blood pressure) 2 take one tablet by mouth twice daily. Review of Resident #6's August 2020 elect medication administration record (eMAR) fr 08/01/20-08/13/20 revealed: -There was a computer-generated entry for bumetanide (to treat high blood pressure) 2 take one tablet by mouth twice daily. -Bumetanide was not documented as administered at 9:00am on 08/08/20. -There was no reason documented on the eunder "exceptions" or in the electronic prognotes. Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a blister pack of bumetanide 2n with a computer-generated pharmacy label attached and the directions to take one table mouth twice daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blis pack. -There was a second blister pack of bumeta 2mg with a computer-generated pharmacy attached and the directions to take one table mouth twice daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blis pack. e. Review of Resident #'7's current FL2 dat 05/29/20 revealed there was a physician's of for calcium antacid chewable 500mg (to tre calcium levels), take two tablets by mouth the calcium levels and the calciu	emg, ronic rom . emg, eMAR gress ng let by ster anide label let by ster ded order set low		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			0
		HAL060087	B. WING		08	C 8/ 17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
OLIABI O	TT 00114 DE		MEL ROAD	,		
CHARLO	ITE SQUARE	CHARLO	OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 88	D 358			
	medication administra 08/01/20-08/13/20 rev -There was a comput calcium antacid chew tablets by mouth twice -Calcium antacid che as administered at 9:0 -There was no reason	er-generated entry for able 500mg, take two e daily. wable was not documented				
	chewable 500mg with pharmacy label attack chew two tablets by n dispense date of 08/1 -There were 29 tablet packThere was a second antacid chewable 500 computer-generated pand the directions to twice daily and a disp	ration on 08/13/20 at eack of calcium antacid a a computer-generated ned and the directions to mouth twice daily and a 0/20. es remaining in the blister blister pack of calcium				
	was an order dated 0 100mg (to treat const mouth twice daily.	#'7's record revealed there 6/10/20 for docusate sodium ipation), take one tablet by 7's August 2020 electronic				
	medication administra 08/01/20-08/13/20 rev	ation record (eMAR) from				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SU COMPLE	
		HAL060087	B. WING		08/17	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE SQUARE	5820 CAMI				
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	TE, NC 28226	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	2 89	D 358			
D 358	docusate sodium 100 mouth twice dailyDocusate sodium 10 as administered at 9:00-10-10-10-10-10-10-10-10-10-10-10-10-1	Omg was not documented 200am on 08/08/20. In documented on the eMAR of in the electronic progress on 08/13/20 at seach of docusate sodium der-generated pharmacy electronic to take one daily and a dispense date of the seach of docusate computer-generated directions to take one daily and a dispense date of the seach of docusate computer-generated directions to south twice daily and a 0/20. The seach of the	D 358			
	twice daily.	one-half tablet by mouth				

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-There was no reason documented on the eMAR

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					l c l
		HAL060087	B. WING		08/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE	
TO TWIL OF T	NOVIBER OR GOLF EIER	5820 CAM			
CHARLO	TTE SQUARE		TE, NC 28226		
			TE, NC 20220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	9 90	D 358		
	under "exceptions" or notes.	in the electronic progress			
	Observation of Residavailable for administ 12:05pm revealed:				
	-There was a blister p	pack of doxazosin 4mg with			
		d pharmacy label attached take one-half tablet (2mg) by			
	mouth twice daily and	` ` ` ` ` ` `			
	08/10/20.	to remaining in the blister			
	pack.	ts remaining in the blister			
	-There was a second	blister pack of doxazosin			
		-generated pharmacy label ctions to take one-half tablet			
		e daily and a dispense date			
	-There were 28 tablet pack.	ts remaining in the blister			
	05/29/20 revealed the	t #'7s current FL2 dated ere was an order for reat depression), take one			
		7's August 2020 electronic ation record (eMAR) from			
	08/01/20-08/13/20 re	,			
		er-generated entry for			
		e one tablet by mouth daily.			
	at 9:00am on 08/08/2	documented as administered			
		n documented on the eMAR			
		in the electronic progress			
	notes.				
	Observation of Resid	ont #7's modications			
	available for administ				

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12:05pm revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY IPLETED	
		HAL060087	B. WING		0	C B/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
CHARLO	TTE SQUARE		MEL ROAD			
	T		OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	a computer-generate and the directions to daily and a dispense -There were 28 tablet pack. i. Review of Resident 05/29/20 revealed the duloxetine 60mg (to t tablet daily. Review of Resident # medication administra 08/01/20-08/13/20 revenue was a comput duloxetine 60mg, take -Duloxetine was not cat 9:00am on 08/08/2 -There was no reason	pack of duloxetine 30mg with depharmacy label attached take one tablet by mouth date of 08/10/20. Its remaining in the blister #'7's current FL2 dated ere was an order for reat depression), take one reat depression), take one record (eMAR) from wealed: er-generated entry for ere one tablet by mouth daily. In documented as administered 0. In documented on the eMAR in the electronic progress ent #7's medications ration on 08/13/20 at	D 358			
	-There was a bubble with a computer-gene attached and the dire mouth daily and a dis	pack of duloxetine 60mg erated pharmacy label ctions to take one tablet by pense date of 08/10/20. es remaining in the blister				
	05/29/20 revealed the metoprolol tartrate 50 pressure), one tablet	mg (to treat high blood by mouth twice daily.				
		7's August 2020 electronic ation record (eMAR) from				

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MANE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S820 CAMEL ROAD CHARLOTTE SQUARE SUMMARY STATEMENT OF DESIGNATION SUMMARY STATEMENT OF DESIGNATION PREPRIX TAG SEGULATORY OR LSC IDENTIFYING INFORMATION) DESIGNATION OF DESIGNATION OF DESIGNATION PREPRIX TAG D 358 Continued From page 92 05/01/20-08/13/20 revealed: -There was a computer-generated entry for metoprolol lartrate 50mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth twice daily and a dispense date of 08/10/20. -There was a second bilister pack of metoprolol lartrate 50mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth twice daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the bilister pack. -There were 28 tablets remaining in the bilister pack. -There were 28 tablets remaining in the bilister pack. Review of Resident #7's current FL2 dated 05/29/20 revealed through the daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the bilister pack. Review of Resident #7's current FL2 dated 05/29/20 revealed through the daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the bilister pack. Review of Resident #7's current FL2 dated 05/29/20 revealed threre was a physician's order for oxycodone 5mg (to treat moderate pain), take two tablets by mouth wice daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the bilister pack. Review of Resident #7's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for oxycodone 5mg (to treat moderate pain), take two tablets by mouth every four hours.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 72P CODE S220 CAMEL ROAD CHARLOTTE, NC 32225 COMPILETE, NC 32225 COMPILETE, NC 32225 CHARLOTTE, NC 32225 CHARLOT				_		C	
CHARLOTTE SQUARE CANADO CHARLOTTE, NC 28226			HAL060087	B. WING			
CHARLOTTE SQUARE CHARLOTTE, NC 28226	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHARLOTTE, NC 28226 PREFIX SUMMARY STATEMENT OF DEFICIENCISS DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE	CHARLOT	TE SQUARE					
PREFIX TAG CACH CORRECTIVE ACTION SYOULD BE CROSS-REPERENCE DISTRIPTIVE INFORMATION			CHARLOT	TE, NC 28226			
08/01/20-08/13/20 revealed: -There was a computer-generated entry for metoprolol tartrate 50mg, take one tablet by mouth twice daily. -Metoprolol tartrate was not documented as administered at 9:00am on 08/08/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a blister pack of metoprolol tartrate 50mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth twice daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. -There was a second blister pack of metoprolol tartrate 50mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth twice daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. -There was a second blister pack of metoprolol tartrate 50mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth twice daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. k. Review of Resident #7's current FL2 dated 05/29/20 revealed there was a physician's order for oxycodone 5mg (to treat moderate pain), take two tablets by mouth every four hours. Review of Resident #7's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for oxycodone 10mg, take one tablet by mouth every	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE	
LIQUI NOUIS.	D 358	08/01/20-08/13/20 rev-There was a comput metoprolol tartrate 50 mouth twice dailyMetoprolol tartrate w administered at 9:00a-There was no reason under "exceptions" or notes. Observation of Resida available for administ 12:05pm revealed: -There was a blister p50mg with a compute attached and the dire mouth twice daily and 08/10/20There were 28 tablet packThere was a second tartrate 50mg with a compute packThere was a second tartrate 50mg with a compute packThere was a second tartrate 50mg with a compare packThere was a second tartrate 50mg with a compare packThere was a second tartrate 50mg with a compare packThere was a second tartrate 50mg with a compare packThere was a second tartrate 50mg with a compare packThere was a second tartrate 50mg with a compare packThere was a second tartrate 50mg with a compare packThere was a second tartrate 50mg with a compare packThere was a second tartrate 50mg with a compare packThere was a second tartrate 50mg with a compare packThere was a second tartrate 50mg with a compare packThere was a second tartrate 50mg with a compare packThere was a second tartrate 50mg with a compare packThere was a second tartrate 50mg with a compare pack.	er-generated entry for mg, take one tablet by as not documented as am on 08/08/20. In documented on the eMAR in the electronic progress ent #7's medications ration on 08/13/20 at eack of metoprolol tartrate regenerated pharmacy label octions to take one tablet by a dispense date of as remaining in the blister blister pack of metoprolol computer-generated end and the directions to eath twice daily and a 0/20. In the electronic entry in the blister end and the directions to eath twice daily and a 0/20. In the electronic entry in the every four hours. The August 2020 electronic entry for electronic e	D 358			

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Division	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURV	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:)
					С	
		1141.000007	B. WING		1	
		HAL060087	B: *******		08/17/2	020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		5820 CA	MEL ROAD			
CHARLOT	TE SQUARE		TTE, NC 28226			
			711L, NO 20220			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) OMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
1710		,	,,,,,	DEFICIENCY)		
D 358	Continued From page	e 93	D 358			
	administered at 8:00a	am on 08/08/20				
		n documented on the eMAR				
		r in the electronic progress				
	notes.	in the electronic progress				
	notes.					
	Observation of Resid	ant #7'a madications				
	available for administ					
		ration on 06/15/20 at				
	12:05pm revealed:					
		pack of oxycodone 10mg				
	-	erated pharmacy label				
		ctions to take one tablet by				
		rs and a dispense date of				
	08/07/20.					
		tablets remaining in the				
	blister pack.					
		blister pack of oxycodone				
	-	er-generated pharmacy label				
		ctions to take one tablet by				
	-	rs and a dispense date of				
	08/07/20.					
		tablets remaining in the				
	blister pack.					
	I. Review of Resident	:#'7s current FL2 dated				
	05/29/20 revealed the					
	pantoprazole (to treat	t acid reflux) 40mg daily.				
		7's August 2020 electronic				
		ation record (eMAR) from				
	08/01/20-08/13/20 re					
		er-generated entry for				
	pantoprazole 40mg, t					
	-Pantoprazole was no					
	administered at 9:00a					
	-There was no reason	n documented on the eMAR				
	under "exceptions" or	in the electronic progress				
	notes.					
	Observation of Resid	ent #7's medications				

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available for administration on 08/13/20 at

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DIVISION	n riealin Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
						,
		HAL060087	B. WING		1	, 7/2020
					1 00/1	
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE SQUARE	5820 CAM				
	•	CHARLOT	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	94	D 358			
	with a computer-general attached and the direct daily and a dispense of a computer where 28 tablet pack. m. Review of Resider 05/29/20 revealed the 18mcg, inhale one can ebulizer once daily. Review of Resident #	ctions to take one tablet date of 08/10/20. s remaining in the blister at #'7s current FL2 dated ere was an order for Spiriva psule via hand held 7's August 2020 electronic				
	08/01/20-08/13/20 rev-There was a compute Spiriva 18mcg, inhale nebulizer once dailySpiriva was not docu 9:00am on 08/08/20There was no reason					
	18mcg capsules with pharmacy label attach					
	nurse on 8/14/20 at 1 1:07pm revealed she missed all morning m	with Resident #7's Hospice :20pm and 8/17/20 at was unaware that he had edications on 08/08/20.				

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at 2:00pm was unsuccessful.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		C
		HAL060087	B. WING		08/17/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
CHARLOT	TE SQUARE		MEL ROAD		
		CHARLO	TTE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 358	Continued From page	95	D 358		
	(HWN) on 08/13/20 a not aware that Reside medications were not	administered on 08/08/20. interview with Resident #7's			
	Refer to telephone int (MA) on 08/11/20 at 1	terview with medication aide 11:20am.			
	Refer to interview with 2:30pm.	h the HWD on 08/13/20 at			
	Refer to telephone in 08/17/20 at 10:23am.	terview with the lead MA on			
	-	terview with the pharmacist cted pharmacy on 08/17/20			
	Refer to interview with 08/17/20 at 3:53pm.	h the Administrator on			
	(PCA) on 08/11/20 at -During the past few of double shifts, first and staff shortageThere were times du MA in the SCUOn 08/08/20 when si and there was not a Nather -The residents did no on first shift or second -She contacted a MA work on the morning	weeks she had worked d second shifts, due to a ring this period there was no he was working in the SCU MA. t receive their medications d shift. that was not scheduled to			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILANC	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COWII LETED
		HAL060087	B. WING		C 08/17/2020
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	00.11.2020
		5820 CAM	EL ROAD		
CHARLOT	TE SQUARE		TE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
D 358	Continued From page	96	D 358		
	-The staff responsible vacation and she did	e for scheduling was on not contact management. with a medication aide (MA)			
	-At times, there was r	n revealed: / in the SCU as a MA. not a MA scheduled to work			
	in the SCU. -The residents in the SCU would have to wait until the MA passing medications in the Assisted Living building had completed her medication pass. -The MA would then come down to the SCU building and pass medications to the residents.				
	Telephone interview with another MA on 08/11/20 at 11:20am revealed: -She worked as a medication aide (MA) in the Special Care Unit (SCU)The MAs float between the Assisted Living (AL) building and the SCU due to a staff shortageWhen the buildings share a MA, they had to hurry through the medication pass in each buildingRecently there were shifts residents did not receive all their medicationsShe could not recall which dates this occurredThe documentation where the MAs initial on the eMAR was blank and there was no note under "Exceptions" or the e-progress notes.				
	Living communities. -If there was no MA in Living MA would go to administer medication. -The MA would admin Assisted Living reside	revealed: the SCU and the Assisted the SCU, the Assisted the SCU community and the SCU medications to the			

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 358 Continued From page 97 D 358 administer medications to the residents in the		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
CHARLOTTE SQUARE CHARLOTTE, NC 28226		HAL060087		B. WING		1	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 97 administer medications to the residents in the			5820 CAME	L ROAD	TE, ZIP CODE		
administer medications to the residents in the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
SCU. She received a call from the SCU staff on 08/08/20 requesting she come in to administer medications to the SCU residents. -There was no Ma scheduled for the SCU community. -She did not know why the MA assigned to the Assisted Living community did not administer medications to the SCU residents after the Assisted Living medication pass was completedIt was her day off and she did not come in to the facilityShe did not know if anyone else was contactedShe did not contact management. Telephone interview with the lead MA on 08/17/20 at 10:23am revealed: -She worked as a MA in the AL communityShe had also been the staff scheduler for the MAs and PCAs, staffing both the AL and SCU communities for the past monthIf there was a callout or staff did not report for their shift, she would notify management and get coverage from in house staff or a staffing agencyShe also reviewed the eMARs on the AL. community and reported to the Health and Wellness nurse if there was no documentation a medication had been administeredShe would contact the MA to determine the cause of the missed medication documentation and report to the Health and Wellness nurseShe did not complete any Medication Incident Reports. Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2.45pm revealed: -The facility was on a monthly cycle fill for	D 358	administer medication SCU. -She received a call for 08/08/20 requesting is medications to the SC -There was no MA so community. -She did not know who Assisted Living community and report to the SC Assisted Living medicality. -She did not know if a she did not contact in the state of the policy of the polic	rom the SCU staff on she come in to administer CU residents. heduled for the SCU by the MA assigned to the nunity did not administer CU residents after the cation pass was completed. It is a staff or a staff or a staffing agency are eMARs on the AL to the Health and re was no documentation and Wellness nurse. It is any Medication Incident with the pharmacist at the narmacy on 08/17/20 at	D 358			

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scheduled medications.

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DIVISION	n rieaith Service Negu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ETED
			_			
					C	;
		HAL060087	B. WING		08/1	7/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ALE, ZIP CODE		
CHARLOT	TE SQUARE	5820 CAM	EL ROAD			
CHARLO	IL SQUARE	CHARLOT	TE, NC 28226			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 358	Continued From page	. 08	D 358			
D 330	Continued From page	: 90	5 330			
	-The cycle fill medicat	tions were delivered to the				
	facility prior to the nex	kt month's cycle date.				
	-The cycle date for the	e new month was to begin				
	on the 10th of each m	nonth.				
	-A thirty- or thirty-one-	-day supply of the				
		d in blister packs to be				
		eginning of the new cycle.				
		for controlled substances,				
	•	n the previous month could				
		or returned to the pharmacy.				
	-There was no trackin					
		to the pharmacy that were				
	not controlled substar	· · · · · · · · · · · · · · · · · · ·				
		edications were filled when				
	requested by the facil					
		Pens were also filled when				
	requested by the facil	ity stair.				
	Interview with the Hea	alth & Wellness Nurse				
	(HWN) on 08/13/20 a					
		for physician's orders and				
	medications in the co					
	-She supervised the N					
	-The MAs refer to the					
	administration of med					
		ewed a Variance report				
	detailing medications	that have been missed.				
	-If the initials of the M	A were not documented for				
	the administration of a	•				
	exception noted, it was	as captured on the Variance				
	report as a missed me	edication.				
	-She was printing this	report several times a				
	week.					
	-Recently she only go	ot a chance to print this				
		e she was preoccupied with				
	•	·				
	=	, , -				
		and toport and today				
	many other responsib Special Care Coordin	oilities given to her since the				

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-The last time she printed the variance report was

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	A. A.		A. BUILDING: _		COMPL	EIED
		HAL060087	B. WING		08/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE SQUARE	5820 CAMI	EL ROAD			
		CHARLOT	TE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	was not administered 08/08/20 until today (0 asked to print the represented the SC a MA so all the reside medications. -The staff was instructif there was a staff shewould come in the a replacement for the she was not contacted there was no MA on Staffing there was a callout. -Occasionally, the MA come down to the SC if there was a callout. -She did not know who contacted to administ 08/08/20. Interview with the Adr 3:53pm revealed: -The HWN was responsand medications in the HWN supervised. -The supervisor in chastaffing schedule each of their shift, the scheduler. -The scheduler was callout report for their shift, the scheduler was call the HWN or the Armough 08/12/20. -If the scheduler was call the HWN or the Armough 08/12/20. -The HWN printed an report detailing medical report detailing medical report detailing medical report shift, and report detailing medical report detailing medical report detailing medical report shift, and report detailing medical report shift, and report detailing medical report shift, and report detailing medical report shift report detailing medical report shift report shift, and report detailing medical report shift rep	the residents on the SCU and of their medications on 08/13/20) when she was ort. CU and AL to be staffed with ents would receive all their sted to contact management ortage. To the facility to assist or find MA. The staff to inform her SCU on 08/08/20 to the staff to inform her SCU on 08/08/20 to the staff to inform her SCU on 08/08/20 to the staff to inform her SCU on 08/08/20 to the staff to inform her SCU on 08/08/20 to the staff to inform her SCU on 08/08/20 to the staff to inform her SCU on 08/08/20 to the staff to inform her SCU on 08/08/20 to the staff to inform her SCU on 08/08/20 to the staff to inform her SCU on 08/08/20 to the staff to inform her SCU on 08/08/20 to the staff person did not the MAs and the PCAs. The staff person did not the MA on the shift would call the staff should administrator. The staff should dedininistrator.	D 358			
	missed. -She had not been re	viewing the report as				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				c		
		HAL060087	B. WING		08/17/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE SQUARE		MEL ROAD			
040.15	CLIMMA DV. CT.		TTE, NC 28226	DROVIDER'S DLAN OF CORRECTION	1 05	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	100	D 358			
	-She would have seen printed the Variance respected anyone was not a MA available 08/08/20 to call mana -She did know the respective medications 08/08/20 -There was not a menteam assigned on call the management team telephoneThe staff failed to conserve the conserve of the conserve	e of the staff that knew there le to pass medications on gement. idents missed all their until today (08/13/20). inber of the management of the weekends, but all in was accessible by immunicate the problem.				
	The facility failed to administer medications as ordered by a licensed prescribing practitioner for 6 of 7 sampled residents. In addition the facility neglected to give any medications to 15 of 15 residents residing in the Special Care Unit who did not receive any medication on 08/08/20, and two residents on the Assisted Living side who missed all morning medications on 08/08/20 and 08/09/20. This failure resulted in substantial risk of neglect and harm to the residents and constitutes a Type A2 Violation.					
	this violation.	131D-34 on 08/14/20 for				
	CORRECTION DATE VIOLATION SHALL N 16, 2020.	FOR THE TYPE A2 OT EXCEED SEPTEMBER				
D 465	10A NCAC 13F .1308	(a) Special Care Unit Staff	D 465			
		Special Care Unit Staff sent in the unit at all times in neet the needs of the				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		HAL060087	B. WING		C 08/17/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	•	
		5820 CAM	EL ROAD			
CHARLO	TTE SQUARE	CHARLO1	TE, NC 28226			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		
D 465	Continued From page	÷ 101	D 465			
	residents: but at no tir	ne shall there be less than				
	*	meets the orientation and				
	training requirements					
	Section, for up to eigh	nt residents on first and				
	second shifts and 1 h	our of staff time for each				
		nd one staff person for up to				
		shift and .8 hours of staff				
	time for each addition	al resident.				
	This Rule is not met	as evidenced by:				
	TYPE B VIOLATION					
	Based on interviews a	and record reviews, the				
	facility failed to ensure					
	1	eeds of Special Care Unit				
	(SCU) residents for 23	3 of 48 shifts sampled for 16				
	days from 07/10/20 to	08/08/20.				
	The findings are:					
	Review of NCDHHS E	Emergency Staffing				
	Recommendations du					
	pandemic revealed:	Ğ				
	-Staff who test positiv	e for COVID-19 will be				
	unable to work until th	ney meet the criteria for				
	returning to work. This	s can cause sudden staffing				
	shortages at a time w	hen extra work is required				
	to control the outbrea					
		pare for the possibility of				
		d have a concrete plan with				
		if they do need additional				
	staff.	a should be considered for				
		s should be considered for				
	emergency staffing: -Allowing caregivers t	hat are positive but				
		areas dedicated to caring				
	• •	[while wearing appropriate				
	personal protective ed					

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
						С
		HAL060087	B. WING		08	3/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
			MEL ROAD			
CHARLO	TTE SQUARE	CHARLO	OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 465	paga		D 465			
	staffing support -Contacting local hos support - If all these options h additional staffing is s department can reque state. Emergency sta several days to fill. Fa searching for addition tested rather than wa back, so these emerg be filled if necessary.	pitals for temporary staffing have been exhausted and still needed, your local health est emergency staff from the effing requests typically take acilities should begin hal staff as soon as staff are eiting for test results to come eyency staffing requests can				
	07/01/20 at 10:28am Review of the facility! Division of Health Set the facility was licens (AL) with a capacity of	but none were provided. s 2020 license from the rvice Regulation revealed ed for an Assisted Living of 100 beds and a Special				
	Review of the Reside 07/09/20 revealed: -There was a SCU ce -The required staff ho hours.	ours for third shift was 20				
		vee Time Detail dated ere were 19 staff hours shift, a shortage of 1.0				
	07/10/20 revealed: -There was a SCU ce	nt Bed List Report dated ensus of 25 residents. ours for first shift was 25				

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Division of Health Service Regulation				(X3) DATE SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					С
		HAL 060087	B. WING		
		HAL060087	D. 111140		08/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	E, ZIP CODE	
			MEL ROAD		
CHARLOT	TE SQUARE		OTTE, NC 28226		
			JITE, NC 20226		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
IAG		,	IAG	DEFICIENCY)	
D 465	Continued From page	e 103	D 465		
	hours				
	hours.	ours for second shift was 25			
		ours for second shift was 25			
	hours.	come for third - Lift 00			
		ours for third shift was 20			
	hours.				
		yee Time Detail dated			
	07/10/20 revealed:				
	-There were 22.06 st	aff hours provided on the			
	first shift, a shortage	of 2.94 hours.			
	-There were 21.05 sta	aff hours provided on the			
	second shift, a shorta	ige of 3.95 hours.			
	-There were 11.00 sta	aff hours for provided on the			
	third shift, a shortage	•			
	, 0				
	Review of the Reside	ent Bed List Report dated			
	07/11/20 revealed:				
	-There was a SCU ce	ensus of 25 residents			
		ours for first shift was 25			
	hours.	and for mot ormit was 20			
		ours for second shift was 25			
	hours.	outs for socioliu stillt was 25			
		ours for third shift was 20			
		ours for third shift was 20			
	hours.				
	Davious of the Carella	voo Timo Dotoil doto-l			
		yee Time Detail dated			
	07/11/20 revealed:	-# h			
		aff hours provided for first			
	shift, a shortage of 4.				
		aff hours provided for the			
	second shift, a shorta				
		ff hours provided on the third			
	shift, a shortage of 11	1.00 hours.			
		nt Bed List Report dated			
	07/12/20 revealed:				
	-There was a SCU ce	ensus of 25 residents.			
	-The required 20 staf	f hours on third shift was 20			
	hours.				

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STATE FORM 6899 2SZ411 If continuation sheet 104 of 118

NAME OF PROVIDER OR SUPPLIER CHARLOTTE SQUARE STREET ADDRESS, CITY, STATE, ZIP CODE S820 CAMEL ROAD CHARLOTTE, NC 28226 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 465 Continued From page 104 Review of the Employee Time Detail dated 07/12/20 revealed there were 9.00 staff hours provided on the third shift, a shortage of 11.00 hours. Review of the Resident Bed List Report dated	C 08/17/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5820 CAMEL ROAD CHARLOTTE SQUARE (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 465 Continued From page 104 Review of the Employee Time Detail dated 07/12/20 revealed there were 9.00 staff hours provided on the third shift, a shortage of 11.00 hours.	08/17/2020
CHARLOTTE SQUARE CHARLOTTE, NC 28226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 465 Continued From page 104 Review of the Employee Time Detail dated 07/12/20 revealed there were 9.00 staff hours provided on the third shift, a shortage of 11.00 hours.	
CHARLOTTE, NC 28226 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 465 Continued From page 104 Review of the Employee Time Detail dated 07/12/20 revealed there were 9.00 staff hours provided on the third shift, a shortage of 11.00 hours.	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 465 Continued From page 104 Review of the Employee Time Detail dated 07/12/20 revealed there were 9.00 staff hours provided on the third shift, a shortage of 11.00 hours.	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 465 Continued From page 104 Review of the Employee Time Detail dated 07/12/20 revealed there were 9.00 staff hours provided on the third shift, a shortage of 11.00 hours. (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	T
Review of the Employee Time Detail dated 07/12/20 revealed there were 9.00 staff hours provided on the third shift, a shortage of 11.00 hours.	
07/12/20 revealed there were 9.00 staff hours provided on the third shift, a shortage of 11.00 hours.	
Review of the Resident Red List Report dated	
07/13/20 revealed: -There was a SCU census of 25 residentsThe required staff hours for second shift was 25 hours.	
-The required staff hours for third shift was 20 hours.	
Review of the Employee Time Detail dated 07/13/20 revealed: -There were 20.16 staff hours provided for the second shift, a shortage of 4.84 hoursThere were 17.25 staff hours provided on the third shift, a shortage of 2.75 hours.	
Review of the Resident Bed List Report dated 07/14/20 revealed: -There was a SCU census of 24 residentsThe required staff hours for second shift was 24 hoursThe required staff hours for third shift was 19.2 hours.	
Review of the Employee Time Detail dated 07/14/20 revealed: -There were 20.10 staff hours provided for the second shift, a shortage of 3.90 hours. -There were 16.9 staff hours provided on the third shift, a shortage of 2.30 hours. Review of the Resident Bed List Report dated 07/15/20 revealed: -There was a SCU census of 21 residents.	

hours.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		SURVEY PLETED
		HAL060087	B. WING		08	C 3 /17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	, , , , ,	
CHARLO	TTE COLLADE	5820 CAI	MEL ROAD			
CHARLO	TTE SQUARE	CHARLO	TTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 465	Continued From page	e 105	D 465			
	-The required staff ho hours.	ours for third shift was 16.8				
	Review of the Employ 07/15/20 revealed:	ee Time Detail dated				
	second shift, a shorta	ff hours provided on the third				
	07/16/20 revealed:	nt Bed List Report dated				
	-There was a SCU ce -The required staff ho hours.	ensus of 22 residents. ours for third shift was 17.60				
	07/16/20 revealed the	/ee Time Detail dated ere were 9.00 staff hours shift, a shortage of 8.6				
	07/17/20 revealed: -There was a SCU ce	nt Bed List Report dated ensus of 22 residents. ours for third shift was 17.60				
		vee Time Detail dated ere were 9.00 staff hours shift, a shortage of 8.6				
	07/18/20 revealed: -There was a SCU ce	nt Bed List Report dated ensus of 21 residents. ours for third shift was 16.8				
	Review of the Employ 07/18/20 revealed the	vee Time Detail dated ere were 9.00 staff hours				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL060087	B. WING		C 08/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CHARLOT	TE SQUARE	5820 CAME CHARLOT	EL ROAD TE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 465	Continued From page	e 106	D 465		
	provided on the third hours.	shift, a shortage of 7.8			
	Review of the Resident Bed List Report dated 07/19/20 revealed: -There was a SCU census of 21 residentsThe required staff hours for third shift was 16.8 hours.				
	Review of the Employee Time Detail dated 07/19/20 revealed there were 9.00 staff hours provided on the third shift, a shortage of 7.8 hours.				
	Review of the Resident Bed List Report dated 07/20/20 revealed: -The census was 20 residentsThe required staff hours for second shift was 20.0 hoursThe required staff hours for third shift was 16.0 hours.				
	Review of the Employee Time Detail dated 07/20/20 revealed: -There were 15.50 staff hours provide on the second shift, a shortage of 4.50 hoursThere were 9.25 staff hours provided on the third shift, a shortage of 6.75 hours.				
	07/22/20 revealed: -The census was 18 r -The required staff ho hours.	nt Bed List Report dated residents. ours for first shift was 18 ours for third shift was 16			
	Review of the Employ 07/22/20 revealed: -There were 16 staff I	ee Time Detail dated			

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL060087	B. WING		C 08/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CHARLO1	TE SQUARE	5820 CAME			
		CHARLOT	TE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 465	Continued From page	e 107	D 465		
	shift, a shortage of 2There were 11.50 sta second shift, a shorta Review of the Reside	0 hours. aff hours provided on the			
	08/02/20 revealed: -The census was 15 residentsThe required staff hours for third shift was 12 hours.				
	Review of the Employee Time Detail and staff schedule dated 08/02/20 revealed: -There was no MA scheduled for second shiftThere were 9.45 staff hours provided on the third shift, a shortage of 2.55 hours.				
		nt Bed List Report dated e census was 15 residents.			
	Review of the Employee Time Detail and staff schedule dated 08/08/20 revealed: -There was no MA scheduled for first shiftThere was no MA scheduled for second shift.				
	aide (MA) on 08/06/2 -She was the only as: the facility from 11:00 -She was responsible personal care aides (-She was responsible medication to SCU re -She was responsible or accidents involving shiftThe SCU was usual	for ensuring the SCU PCAs) were on the unit. for administering PRN			
		rere numerous occasions of schedule on third shift in the			

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AND PLAN OF CORRECTION IDEN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION	
		A. BUILDING:		COMPLETED
н	AL060087	B. WING		C 08/17/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE	
CHARLOTTE SQUARE	5820 CAME	L ROAD		
CHARLOTTE SQUARE	CHARLOTT	E, NC 28226		
(X4) ID SUMMARY STATEMENT (PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENT	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 465 Continued From page 108		D 465		
In July 2020, the Health & W (HWN) instructed her to inform PCA that the PCA would be residents on third shift. The HWN instructed her to into contact the third shift MA as was an incident or accident or When only one SCU PCA was HWN instructed her to inform only perform incontinence car. When only one SCU PCA was HWN instructed her to tell PC residents up and ready in the shift PCA staff came in to help. She worked an eight-hour shid days per week on third shift, shid additional seven shift hours or unit. The facility had been utilizing agency care staff up until app 2020 due to insufficient facility. She had been informed by the Care Coordinator (SCC), that longer utilizing healthcare starstaff for the SCU. Telephone interview with a thin 08/05/2020 at 5:30 pm reveale. She worked as a third shift Peshe had been working in the June 2020. Around 07/09/2020, there we residents. On 07/11/2020 and 07/12/20 SCU residents and she was thurit for third shift. On 07/11/2020 and 07/12/20	esponsible for 25 esponsible for 25 estruct SCU PCA's esponsible for 25 estruct SCU PCA's esponsible for 25 estruct SCU PCA's esponsible for 25 esponsible for 26 esponsible for 25 esponsible f	D 465		

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	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060087	B. WING		C 08/17/2	020
NAME OF P	ROVIDER OR SUPPLIER		LRESS, CITY, STA	TE. ZIP CODE	1 00/11/2	020
		5820 CAME	, ,			
CHARLOTTE SQUARE			E, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 465	Continued From page	e 109	D 465			
D 465	between 11:00pm and She was not aware of occurring with SCU re 07/12/2020. There were one or two preferred to ambulate third shift, requiring in On the third shifts shiftom the assisted living with her and had instraction to check residents for Scu staff. "There definitely was on third shift for 25 residents of on 08/14/2020 and She began working to the Scu to fill in for significant to check residents. Telephone interview where the Scu to fill in for significant to check residents. Telephone interview where the Scu to fill in for significant to check residents. Telephone interview where the Scu to fill in for significant to to fill in fill in for significant to fill in fill in for significant to fill in	d 7:00am. of any incidents or accidents esidents on 07/11/2020 or ovo SCU residents that and were active during acreased supervision. e worked alone, the MA and unit would come check-in ructed her not to get as much as possible and a incontinence every 2-hours. The mough staff in the SCU sidents in July." with a first and second shift at 12:19pm revealed: both first and second shift in the hift vacancies in July 2020. worked first and second with one MA providing care till approximately approximately are occasions she was the launit for first or second shifts	D 465			
	having one PCA and residentsShe had asked the HAdministrator about s sometime in late July Administrator informe SCU resident census	no MA for up to 25 SCU IWN and facility taffing to resident census				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		7. BOILDING.		С		
HAL060087		B. WING		08/17/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
011451.07	TE COLLABE	5820 CAN	MEL ROAD			
CHARLOI	TE SQUARE	CHARLO	TTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	E
D 465	Continued From page	e 110	D 465			
D 465	Confidential telephon revealed: -The facility had been 2020On first shift, the facione or two PCA's for -On third shift, the facin July 2020She did not know who scheduling staffThe facility had been healthcare agency staschedule up until app 2020The SCU was staffer and utilized one MA or responsible for the enterprise of t	e interview with a MA understaffed since May lity staffed two MA's and the assisted living unit. sility occasionally staffed one of for the assisted living unit was responsible for utilizing an outside aff to fill vacancies in the roximately May or June d by one PCA on third shift on third shift that was atire facility. with a housekeeper & PCA D5am revealed: as a SCU housekeeper on 0. ing on the SCU, she had of the SCU housekeeper, but of HWN to assisted with ersonal care due to working on the SCU, she	D 465			
	first and second shifts approximately 25 resi	s in July 2020 for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING: _			
		HAL060087	B. WING		C 08/17/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CHARLOT	TE SQUARE	5820 CAN	IEL ROAD		
- TARLES	TE OGOANE	CHARLO	TE, NC 28226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 465	Continued From page	2 111	D 465		
	Telephone interview 08/11/2020 at 11:49a -She was responsible living unit staff in July -She scheduled staff schedules and tried to available facility staffThe schedule was sh Administrator for revie-Staff were expected management if they puthere scheduled shiftShe was not responsible healthcare agency stathis was the responsional AdministratorShe was responsible MA to work on the as	with a lead MA on m revealed: for scheduling assisted 2020. according to pre-set staff of fill schedule vacancies with mared with the HWN and the lew. to contact facility planned to call-out before sible for scheduling aff to fill schedule vacancies; billity of the HWN or the			
	staff. Telephone interview with a former SCC on 08/05/2020 at 1:12pm revealed: -She had been working as the SCC since January 2020She had been responsible for scheduling SCU staff through mid-July 2020At the end of June 2020, the Administrator instructed her to no longer schedule healthcare agency staff to fill SCU staffing schedule gaps and only schedule facility staff for all shiftsShe had informed the HWN and the Administrator on multiple occasions in July 2020 about the SCU being understaffed to the resident census and was not provided any additional staffing resources to address the staffing shortageShe had been instructed by the Administrator to include the third shift assisted living unit MA towards the SCU third shift care aide staffing				

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STATEMEN	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					c	
		HAL060087	B. WING		08/17/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHABLO	TE SQUARE	5820 CAN	IEL ROAD			
CHARLO	TE SQUARE	CHARLO	TTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 465	Continued From page	e 112	D 465			
	requirements and utilize one to two PCA's on third shift when available. -The third shift MA "spent very little time in the unit during third shift because she had a lot of responsibilities on the assisted living unit." Telephone interview with the HWN on 08/13/20 at 2:30pm revealed: -The staff had been instructed to contact management if there was a staff shortage. -She would contact a staffing agency to send personnel or she would come in to the facility to assist. -She had not been contacted by the staff that there was no MA on SCU on 08/08/20. -Occasionally, the MA on the AL building would come down to the SCU and pass the medications if there was a callout. -She did not know why the AL MA was not contacted to pass the medications on 08/08/20.					
	with an MA and reside	the SCU would be staffed ents would receive the				
	medications as prescribed by their physicians. Telephone interview with the HWN on 08/14/2020 at 1:07pm revealed: -She was responsible for assuring MA and PCA's met the healthcare and personal care needs of residents. -She was not responsible for scheduling SCU staff prior to August 2020. -Staff scheduling for the SCU was the responsibility the former Memory Care Manager (MCM). -She was aware the SCU was to be staffed with two PCA's and one MA on first and second shifts when the census was 25. -She was not aware if the facility third shift MA counted as care staff hours on the assisted living unit and SCU schedules.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _				
		HAI 060007	B. WING		C		
		HAL060087			08/17/2020		
NAME OF PF	ROVIDER OR SUPPLIER		ORESS, CITY, STA	TE, ZIP CODE			
CHARLOT	TE SQUARE	5820 CAM					
		CHARLOT	TE, NC 28226		T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE		
D 465	Continued From page	e 113	D 465				
J 100	-She expected the thicheck-in with the SCU respond to incidents of PRN medications to Send and spent on the SCU respond to incidents of PRN medications to Send in the SCU respond to th	rd shift MA to occasionally J PCAs during third shift and or accidents and administer SCU residents. w many hours the third shift I during third shift. d to utilize a healthcare past to fill schedule May 2020, the agency was schedule vacancies for the ng unit. d to utilized facility staff I all schedule vacancies to	2 100				
	on 8/17/2020 at 3:19pr-She assigned a lead scheduling AL unit starthe former SCC had scheduling SCU staffr-She and the HWN we scheduling SCU staffr-She did not know a Market SCU on or about a shifts. -She did not know the medications were not 08/08/2020 until 08/16 to her attention. -She did not audit the assignments and staff-She was aware the A approximately 75 resi August 2020 and the approximately 25 resi or fourth week of July	MA to be responsible for aff in July 2020. been responsible for in July 2020. ere responsible for in August 2020. MA was not scheduled on 8/8/2020 for first and second e SCU residents' administered on 6/2020 when it was brought staffing the staff f hours for the SCU. AL unit maintained dents per day in July and SCU maintained dents per day until the third 2020. Ind shift MA had been placed					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.	7. Bollbinto.			
		HAL060087	B. WING		08/1	7/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CHARLOT	TE SQUARE	5820 CAME					
		CHARLOT	TE, NC 28226				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)) BE	(X5) COMPLETE DATE	
D 465	Continued From page	e 114	D 465				
D 403	the assisted living unitable score and the s	t and SCU. rd shift MA to be on the four hours per shift. CU to be staffed with two he SCU had been staffed herous occasions in July o update staff schedules aff called-out, was placed on vacancy was filled with a aff. t sick the lead MA and/or the be notified, so they could take the assignment f on duty failed to notify agement team that they did f to administer medications. contact the facility when check for adequate staffing, if to contact management	D 403				
		interview with contract n resources 08/17/20 at					
	11. IJaili Wele ulisuc	ocaalul.					
	Refer to Tag 338, 10 <i>A</i> Rights.	A NCAC 13F .0909 Resident					
	Refer to Tag 358, 10A Medication Administra						
		nsure the minimum number sent to meet the needs of					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL060087	B. WING		08	C 8/ 17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CHARLOT	TTE SQUARE		MEL ROAD OTTE, NC 28226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 465	for 23 of 48 shifts san 07/10/20 to 08/08/20 in a lack of adequate and administer medic residents was detrim and safety of the residents. The facility provided accordance with G.S for this violation. THE CORRECTION	the Special Care Unit (SCU) mpled for 16 days from . The facility's failure resulted staff on the unit to supervise	D 465			
D914	G.S. 131D-21 Decla Every resident shall I 4. To be free of ment neglect, and exploita This Rule is not met Based on observatio review, the facility fai were free from physic related to Personal C Resident Rights, Mec Special Care Unit Sta The findings are: 1. Based on record re facility failed to ensur were always present residents residing in	as evidenced by: n, interview, and record led to ensure all residents cal abuse and neglect Care and Other Staffing, dication Administration, and	D914			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	A. BUILDING:			COMPLI	EIED	
		HAL060087	B. WING		00/4	; 7/2020
					1 00/1	112020
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
CHARLOT	TE SQUARE	5820 CAMI CHARLOT	TE, NC 28226			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N .	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
D914	Continued From page	e 116	D914			
D914	07/10/20 and 08/13/2 resulted in a lack of a administer medication health, welfare, and s to Tag 0188 10A NCA Care and Other Staffi 2. Based on observatinterviews, the facility guidelines and recomthe CDC, LHD, and N prevention and transmage of disinfectants eliminate the coronav resident temperatures thermometers to do s residents and COVID and gather in common for social distancing; positive residents and into separate rooms v do so; staff not donning when necessary and correctly when indicate retesting COVID negatility diagnosed with hospitalization, 2 dear with COVID-19. Thes harm and neglect. [Red 13F.0909 Resident Red 23. Based on observative reviews, the facility	O. The facility's failure dequate staff on the unit to as was detrimental to the safety of the residents. [Refer AC 13F .0604(e) Personal and (Type B Violation)]. ions, record reviews, and failed to maintain the amendations established by IC DHHS for infection mission during the related to the impropers in order to effectively firus; not screening staff or and not providing reliable o; allowing COVID positive areas without any regard not cohorting COVID to COVID negative residents when there was potential to any the appropriate PPE also not donning PPE ted; and not testing staff or ative residents as instructed and 11 residents residing in the and COVID-19, 1 this, and 3 staff diagnosed e failures resulted in serious effer to Tag D338, 10A NCAC ights (Type A1 Violation)].	D914			
		., #5, #6 and #7), including o control blood sugar, a blood pressure, a				

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DIVISION	n rieaitii Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_			
					C	;
		HAL060087	B. WING		08/1	7/2020
			I.			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		5820 CAME	L ROAD			
CHARLOTTE SQUARE CHARLOTTE, NC 28226						
		CHARLOT	E, NC 20220			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEI IOIENOT)		
D914	Continued From page	. 117	D914			
D314	Continued From page	: 117	5514			
	medication for nerve	pain, an anticoagulant,				
		edication for cholesterol and				
		(Resident #5); medications				
	for bipolar disorder ar					
	,	ations to treat depression,				
	dementia, chronic pai	n, cholesterol, to control				
	blood sugar, to contro	ol blood pressure, and a				
	mood stabilizer (Resid	dent #4), medications for				
	`	lux, and high blood pressure				
		ations for pain, anxiety and				
	,	•				
	high blood pressure (•				
	-	control, high blood pressure,				
		ratory issues (Resident #7).				
	In addition, the facility	failed to ensure 15 out of				
	15 residents, residing	in the Special Care Unit,				
	_	tion on 08/08/20, and two				
		sted Living community				
		•				
		tions on 08/08/20 and				
	=	ag 0358, 10A NCAC 13F				
		Administration (Type A2				
	Violation)].					
	4. Based on record re	views and interviews, the				
		e the minimum number staff				
	were always present					
	• •					
		he Special Care Unit (SCU)				
		npled for 16 days from				
		The facility's failure resulted				
	in a lack of adequate	staff on the unit to supervise				
	and administer medic	ations for dementia				
	residents was detrime	ental to the health, welfare,				
		dents. [Refer to Tag 0465,				
	-	(a) Special Care Unit				
	Staffing (Type B Viola	iuon)j.				

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