STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual and follow-up survey and a complaint investigation on 07/07/21 through 07/09/21, 07/12/21 with an exit date of 07/13/21.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the floors and floor coverings were kept clean and in good repair in the common areas and hallways in both the assisted living floors and the Special Care Unit (SCU), related to a resident's bedroom on the first floor that had brown staining and dried liquid staining on the carpets, dried brown staining on the mattress and box spring, and a strong smell of urine and feces (Resident #6 and #21), two additional bedrooms with a pungent odor of urine (Resident #7 and #3), urine puddled on the floor with paper towels over the urine (Resident #3), and a hole in the ceiling in the common area where residents congregate to watch TV and a large dried water stain on the rug below.	D 074		

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D 074	Continued From page 1 The findings are: Observation of Resident #7's room, in the Special Care Unit (SCU) on 07/07/21 at 9:50am revealed: -The resident was lying in bed. -There was a strong smell of urine in the room. -There was white powder on the floor throughout the room. Interview with the Hospice Registered nurse (RN) on 07/08/21 at 11:30am revealed: -The RN visited the resident twice a week. -The nurses assistant (NA) provided care for Resident #7. -The room always smelled like urine and there was frequently urine on the floor in her room. -The floor was always sticky and she almost slipped on the urine on the floor in the room the last time she visited. Interview with a housekeeper on 07/09/21 at 11:20am revealed: -She worked on the three floors as needed. -She usually did not go to the Special Care Unit (SCU). -They were short staffed and did not have a housekeeper designated to that floor. -She assisted with the cleaning in SCU when she could. -She would deep clean a few rooms each day on her assigned floor. -There were residents in the SCU who urinated on the floor. -The staff in the SCU was expected to clean the urine on the floor until she finished her work on the Assisted Living side of the facility and could attend to it. -There were cleaning supplies in the housekeeping closet in the SCU. -She sprinkled baking soda on the rugs and floors	D 074		

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D 074	Continued From page 2	D 074		

to help rid the rooms of the smell of urine.
-There was a resident in the SCU who frequently urinated in Resident #7's room.
.-She had cleaned the floor several times over the past few weeks.

Interview with the personal care aide (PCA) on 07/07/21 at 10:05am revealed:
-She had just checked Resident #7's brief and she was dry.
-She did not know why there was a smell of urine in the room because there were no soiled clothes in the laundry basket.
-She did not know why there was white powder on the floor.
-She did not know if other residents urinated on the floors in the SCU.
-She would contact housekeeping if there was any soiling on the floors or rugs.

Observation of room #321 on 07/12/21 at 11:30am revealed Resident #6's room and bathroom had a strong smell of urine.

Interview with a medication aide (MA) on 07/12/21 at 11:40am revealed:
-Ther esidents often used the bathroom on the floor and staff did not always immediately know about it to clean it up.
-Housekeeping cleaned room #321 regularly and upon request as needed.
-Sometimes staff partically opened the window in the room so fresh air could help with the odor.

Interview with a housekeeper on 07/12/12 at 12:20pm revealed:
-She was assigned to clean room #321 on a weekly schedule.
-Staff would often request her to clean room #321 on unscheduled day due to odors, and she

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D 074	Continued From page 3	D 074		

usually cleaned it several times a week.
-She used bleach to mop the floors and opened the window to help it dry and air out.
-The floors in her room were less than a year old year old and she thought the urine odor had seeped between the floorboards, which made it difficult to clean them.

Interview with Maintenance Director on 07/12/21 at 12:40pm revealed:
-Staff did not clean up urine and feces in room #321 as well as in other parts of the facility in a timely manner, which allowed the urine and odors to seep between the boards and become trapped.
-Housekeeping reported that when they were called to clean up urine and feces throughout the facility they often found the urine dried and sticky, and feces to be hard and dry, as though it has been sitting for some time.

Observation of room #202 on 07/07/21 at 9:15am revealed:
-The room had a strong smell of feces.
There were two brown soiled areas on the carpet in the resident's living area.
-The largest area appeared smudged, was irregular in shape, and was approximately 5 inches by 5 inches.
-The second area did not appear smudged, was irregular in shape, and was approximately 1 inch by 1 inch.

Interview with Personal Care Aide (PCA) on 07/07/21 at 9:15am revealed:
-She was agency staff and had worked at the facility for approximately one to two months.
-The room smelled of feces.

Interview with a housekeeper on 07/07/21 at 9:20am revealed:

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 074	Continued From page 4	D 074		

-She usually did not work on the floor with room #202 but was assigned it that day.
-She felt the brown areas on floor of room #202 looked and smelled like feces.

Interview with the Executive Director on 07/07/21 at 9:35am revealed:
-She was unsure, but she thought the resident in room #202 had feces on her floor previously.
-She thought the brown areas on the carpet of room #202 looked and smelled like feces.

Observation of room #202 on 07/09/21 at 9:45am revealed the Maintenance Director was cleaning the carpet using an industrial carpet cleaner.

Interview with the Maintenance Director on 07/09/21 at 9:45am revealed:
-He was responsible for cleaning the carpets when a resident spills something or has an accident on the carpet.
-He used an industrial carpet cleaner in order to remove feces and urine from the floor.
-He cleaned room #202 several times since 07/01/21.
-Room 202 was on the list as the next room for the carpet to be replaced with a laminate flooring which would be easier to clean.

Second observation of room #202 on 07/09/21 at 11:30am revealed:
-There was a large circular area of the carpet, approximately 12 inches by 12 inches in the middle of the floor between the bed and the bathroom that was a brown color.
-There was a strong odor of urine and feces.
-There were other dark stains on the carpet beside the bed.

Interview with another housekeeper on 07/09/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 074	Continued From page 5 at 11:30am revealed: -She was responsible for dusting, vacuuming and general cleaning of the residents' room. -The Maintenance Director was responsible for cleaning the carpet of the resident's rooms. -The resident had accidents such as urination and defecation on the floor, and spilled food and liquids on the floor multiple times. -She tried to use baking soda on the floor to draw out the odor but after so long, it did not work. -She opened the windows to air out the room but the urine odor was so bad. -The urine odor sometimes burned her eyes. -The Maintenance Director used the carpet cleaner in room #202 multiple times.	D 074		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Type B Violation Based on observations and interviews the facility failed to ensure hot water temperatures at 10 of 10 fixtures accessible to residents (sinks in rooms 101, 104, and 113 on the Special Care Unit (SCU) and rooms 221, 204, 224, 228, and	D 113		

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THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 113	Continued From page 6 304 on the Assisted Living (AL) were maintained between 100 degrees Fahrenheit (F) and 116 degrees F. The findings are: Observations during the initial tour of the AL on 07/07/21 between 9:30am and 11:30am revealed: -At 9:58am, the hot water temperature at the bathroom sink in resident room 225 was 118 degrees F. -At 10:03am, the hot water temperature at the bathroom sink in resident room 222 was 118 degrees F. -At 10:15am, the hot water temperature at the bathroom sink in resident room 326 was 120 degrees F' Observations during the initial tour of the AL on 07/07/21 between 10:30am and 12:30pm revealed: -At 10:35am, the hot water temperature at the bathroom sink in resident room 221 was 118 degrees F. -At 10:42am, a second hot water temperature was obtained using a second thermometer, at the bathroom sink in resident room 222 was 118 degrees F. -At 10:50am, the hot water temperature at the bathroom sink in resident room 224 was 118 degrees F. -At 09:58am, a second hot water temperature was obtained using a second thermometer, at the bathroom sink in resident room 225 was 118 degrees F. -At 11:02am, the hot water temperature at the bathroom sink in resident room 228 was 120 degrees F. -At 11:30am, the hot water temperature at the bathroom sink in resident room 213 was 120	D 113		

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D 113	Continued From page 7	D 113		

degrees F.
-At 12:00pm, the hot water temperature at the bathroom sink in resident room 304 was 122 degrees F.

Observations during the initial tour of the SCU on 07/07/21 between 10:30am and 12:30pm revealed:
-At 12:20pm, a hot water temperature was obtained using a second thermometer, at the bathroom sink in resident room 101 was 120 degrees F.
-At 12:25pm, a hot water temperature was obtained using a second thermometer, at the bathroom sink in resident room 104 was 122 degrees F.
-At 12:30pm, a hot water temperature was obtained using a second thermometer, at the bathroom sink in resident room 113 was 118 degrees F.

Review of the local Environmental Health Report dated 07/07/21 at 9:40am revealed the inspectors observed hot water temperatures ranging from 120 to 122 degrees F at resident accessible handwashing sinks and bathing facilities in the AL and SCU.

A request was made on 07/07/21 and 07/08/21 for the water temperature logs, were not available prior to survey exit.

Interview with the local environmental health department representative on 07/07/21 at 12:30pm revealed:
-Hot water temperatures 116-120 degrees F puts residents at risk for scalding especially if exposed to the hot water for 5 minutes.
-At 12:20pm, he obtained a hot water temperature of 120 degrees F in the bathroom

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 113	Continued From page 8	D 113		

sink in resident room 101.
-At 12:25pm, he obtained a hot water temperature of 122 degrees F in the bathroom sink in resident room 104.
-At 12:30pm, he obtained a hot water temperature of 118 degrees F in the bathroom sink in resident room 113.
-There was an increased risk for second and third degree burns with hot water temperatures greater that 120 degrees F with less than a 5 minute exposure.

Interview with the resident residing in room 221 on 07/07/21 at 10:35am revealed:
-The water was very hot.
-She had not burned herself with the hot water.
-She knew how to adjust the running water by using the faucet.

Based on observations, record review and interviews, it was determined the resident from room 101 in the SCU on 07/07/21 at 12:20pm was not interviewable.

Based on observations, record review and interviews, it was determined the resident from room 104 in the SCU on 07/07/21 at 12:25pm was not interviewable.

Based on observations, record review and interviews, it was determined the resident from room 113 in the SCU on 07/07/21 at 12:30pm was not interviewable.

Review of the facility hot water temperature log book dated 05/31/21 revealed:
-In room 101, the documented hot water temperature was documented as 124 degrees F.
-In room 107 the documented hot water temperature was documented as 126 degrees F.

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 113	Continued From page 9 -In room 115, the documented hot water temperature was documented as 121 degrees F. -In room 204, the documented hot water temperature was documented as 118 degrees F. -In room 217, the documented hot water temperature was documented as 122 degrees F. -In room 218, the documented hot water temperature was documented as 120 degrees F. -In room 228, the documented hot water temperature was documented as 122 degrees F. -In room 331, the documented hot water temperature was documented as 121 degrees F. -In room 333, the documented hot water temperature was documented as 124 degrees F. -In room 334, the documented hot water temperature was documented as 120 degrees F. -In room 335, the documented hot water temperature was documented as 122 degrees F. Review of the facility hot water temperature log book dated 06/08/21 revealed: -In room 107, the documented hot water temperature was documented as 122 degrees F. -In room 109, the documented hot water temperature was documented as 120 degrees F. -In room 115 the documented hot water temperature was documented as 118 degrees F. -In room 205, the documented hot water temperature was documented as 122 degrees F. -In room 214, the documented hot water temperature was documented as 120 degrees F. -In room 218, the documented hot water temperature was documented as 124 degrees F. -In room 228, the documented hot water temperature was documented as 119 degrees F. -In room 304, the documented hot water temperature was documented as 122 degrees F. -In room 332, the documented hot water temperature was documented as 122 degrees F. -In room 335, the documented hot water	D 113		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 113	Continued From page 10	D 113		

temperature was documented as 119 degrees F.
-In room 336, the documented hot water temperature was documented as 124 degrees F.

Review of the facility hot water temperature log book dated 06/14/21 revealed:
-In room 102, the documented hot water temperature was documented as 120 degrees F.
-In room 104, the documented hot water temperature was documented as 124 degrees F.
-In room 105, the documented hot water temperature was documented as 122 degrees F.
-In room 203, the documented hot water temperature was documented as 122 degrees F.
-In room 211, the documented hot water temperature was documented as 120 degrees F.
-In room 216, the documented hot water temperature was documented as 119 degrees F.
-In room 218, the documented hot water temperature was documented as 119 degrees F.
-In room 306, the documented hot water temperature was documented as 122 degrees F.
-In room 321, the documented hot water temperature was documented as 120 degrees F.
-In room 326, the documented hot water temperature was documented as 123 degrees F.
-In room 336, the documented hot water temperature was documented as 122 degrees F.

Review of the facility hot water temperature log book dated 06/21/21 revealed:
-In room 102, the documented hot water temperature was documented as 120 degrees F.
-In room 104, the documented hot water temperature was documented as 124 degrees F.
-In room 105, the documented hot water temperature was documented as 122 degrees F.
-In room 203, the documented hot water temperature was documented as 122 degrees F.
-In room 211, the documented hot water

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 113	Continued From page 11	D 113		

temperature was documented as 120 degrees F.
-In room 216, the documented hot water temperature was documented as 119 degrees F.
-In room 218, the documented hot water temperature was documented as 119 degrees F.
-In room 306, the documented hot water temperature was documented as 122 degrees F.
-In room 321, the documented hot water temperature was documented as 120 degrees F.
-In room 326, the documented hot water temperature was documented as 123 degrees F.
-In room 336, the documented hot water temperature was documented as 122 degrees F.

Review of the American Burn Association Scald Injury Prevention dated 04/25/17 revealed:
-Older adults have thinner skin so hot liquids cause deeper burns with even brief exposures.
-Their ability to feel heat may be decreased due to certain medical conditions or medications so they may not realize water was too hot until the injury had occurred.
-The elderly have poor microcirculation, heat was removed from the burned site rather slowly compared to younger adults.
-Changes in a person's intellect,perception, memory, judgement or awareness may hinder the person's ability to recognize a dangerous situation or respond appropriately to remove themselves from danger.
-A hot water temperature of 120 degrees F for 2 minutes was the time for a second degree burn to occur.
-A hot water temperature of 120 degrees F for 5 minutes was the time for a third degree burn to occur.
-A hot water temperature of 124 degrees F for 2 minutes was the time for a second degree burn to occur.
-A hot water temperature of 124 degrees F for 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 113	Continued From page 12 minutes was the time for a third degree burn to occur. Interview with a medication aide (MA) on 07/08/21 at 8:00am revealed: -She worked in the SCU for about 6 months. -She adjusted the water temperature using more cold water because the hot water was very hot. -She informed the Maintenance Director (MD) a few months ago and was told the hot water temperature was "within regulations" so she assumed it was ok. -She thought 120 degrees was safe but depended on the MD because that was his job and she just knew "what felt too hot". -She was not told the water was turned off for repair in the SCU. -She did not see anyone working on the water since she was hired. Interview with a personal care aide (PCA) on 07/08/21 at 8:45am revealed: -She worked in the SCU. -She started at the facility 5 months ago -She did not know what the safe hot water temperatures were, she adjusts the water a little on the cooler side unless the resident said it was too cold. -She reported hot water temperatures were hotter than usual to the MD soon after she started. -She was told the hot water was "with in regulations" so she never said anything again. -The hot water temperature was 120 degrees F. when the MD checked it after she informed him about it. -She did not say anything more about the hot water feeling hot to her because the MD was responsible for knowing the safe hot water temperature.	D 113		

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 113	Continued From page 13 Interview with the ED on 07/08/21 at 3:00pm revealed: -The MD was responsible for documenting the weekly water temperatures in a binder that should be kept at the front desk. -He should be taking a random water temperature readings throughout the community daily. -She received a monthly report from the MD on any water temperature readings that were not within regulatory range. -She would have to review the regulatory water temperature range because she was not sure what the normal range was. -There was an environmental engineer from a sister facility who should provide support for the MD if needed. -She was not aware the water temperatures in the SCU, the first, second and third floor of the assisted living facility were above 116 degrees in 11 rooms tested. -Her expectation was that the MD would be taking random water temperature readings in the residents rooms and the common shower rooms weekly. -She should also be notified if these readings were out of the acceptable temperature range. Interview with the ED on 07/09/21 at 1:15pm revealed the MD had documented the water temperatures electronically as directed by his supervisor. Telephone interview with a MD from a sister facility on 07/09/21 at 2:15pm revealed: -He and the Regional MD were responsible for training the facility MD in January 2021. -The training lasted one day and the facility MD shadowed the previous facility MD. -He informed the facility MD the hot water	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 113	Continued From page 14	D 113		

temperatures were not to be above 116 degrees F per the state regulations.
-The MD was responsible for checking the hot water temperatures on a routine basis, enter the findings in the electronic hot water temperature log along with the actions take for hot water temperatures greater that 116 degrees F.
-The actions that were to be completed for hot water temperatures greater than 116 degrees F were to notify the staff in the affected area and shut off the water in the affected rooms.
-If the issue could not be corrected by the MD then the contracted company would be notified immediately.
-A hot water temperature of 120 degrees F could cause burns in the elderly.

Telephone interview with the MD on 07/12/21 at 2:15pm revealed:
-He had been the MD since January, 2021.
-He received his training from another MD at a sister facility and the Regional MD for one day in January, 2021.
-After the one day training with the other MDs, he shadowed the previous facility MD for one day.
-The facility used a boiler and valves to control hot water and cold water by using mixing valves.
-The mixing valves were replaced in December, 2020 or January, 2021 before he started working at the facility.
-It was his understanding from the training he received from the MD from the sister facility, hot water temperatures up to 135 degrees F were acceptable and within the state mandated regulations.
-He did not know hot water temperatures above 116 were above the normal range.
-He was responsible for completing hot water checks on a weekly basis by taking hot water temperatures in 11 resident rooms located in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 113	Continued From page 15	D 113		

Assisted Living (AL) and the SCU.
-He documented the hot water temperatures in the facility's electronic hot water temperature log.
-Since January 2021, he had many temperatures documented in the log that were greater than 116 degrees F and did not attempt to correct the hot water temperatures.
-Prior to 07/07/21, if the hot water temperatures were higher than 135 degrees F, he would notify the staff on the affected halls located on the AL side.
-He would instruct the staff to put up "caution signs" in each AL room affected.
-Prior to 07/07/21, if the hot water temperature were higher than 135 degrees F, he would notify the staff in the MCU and cut off the affected rooms individual water until it was fixed and registered a hot water temperature less than 135 degrees F and then turn the water back on.
-If he was unable to regulate the hot water to the regulatory temperature then he would contact the contracted company to come out and fix the issue.

Telephone interview with the previous Special Care Manager (SCM) on 07/13/21 at 10:00am revealed:
-The MD was responsible for checking hot water temperatures weekly.
-She did not know where he documented them.
-She did not know if there were any issues with the hot water temperatures in the SCU.
-The MAs and PCAs were responsible for letting the MD know if there were any concerns with the hot water temperatures.
-She did not know if there was any documentation for the hot water concerns the MAs and PCAs had in the SCU.
-There was no burns reported to her in the SCU.
-The MD would report during stand up meetings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 113	Continued From page 16	D 113		

every morning that the hot water temperatures were "all good" so she never questioned him.
-There were no time she could recall the water was shut off because of high hot water temperatures.
-She knew that burns could be caused with hot water temperatures greater than 116 degrees F.
-All SCU residents had access to their sinks in their rooms and if the hot water temperature was above 116 degrees F, they could get scalded.
-She did not check hot water temperatures.

Telephone interview with the ED on 07/13/21 at 2:30pm revealed:
-She did not know what the water temperature range was, and where the hot water temperatures were documented.
-The MD was responsible for checking the hot water temperatures weekly and all temperatures checked were to be documented in the electronic hot water temperature log.
-If the hot water temperatures were too hot, the water was to be shut off in the affected areas and she and the staff were to be notified.
-If the MD could not fix the problem then the contracted company would be called.
-She had a meeting every morning with department heads and the MD had always reported "no issues" and the hot water temperatures were "ok".
-She was not aware the hot water temperatures were too hot until 07/07/21 when the local EHD reported it to her during their inspection.
-The MD from the sister facility and the Regional MD was available for support if the MD had issues.
-She did not know why the MD thought that less than 135 degrees F was safe and with in the regulations.
-A burn in the elderly could happen at 120

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 113	Continued From page 17 degrees or less if exposed long enough. _____ The facility failed to ensure hot water temperatures were maintained between 100 and 116 degrees F at the 10 out of 10 sinks resulting in hot water temperatures between 118 degrees F and 124 degrees F in the AL and the SCU. Hot water temperatures at 120 degrees could result in a second degree burn in 2 minutes and a third degree burn in 5 minutes. Hot water temperatures above 124 degrees F could result in a second degree burn within 2 minutes and a third degree burn within 3 minutes. This failure placed the residents at risk for burns, which was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/07/21 for this Violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 27, 2021.	D 113		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record review the facility failed to ensure 5 of 6 sampled staff (Staff	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 137	Continued From page 18 A,B,C,D and E) had no substantiated findings listed on the North Carolina Health Care Personal Registry (HCPR) prior to hire. The findings are: 1. Review of Staff A's, personnel record revealed: -There was no documentation of a Health Care Personal Registry (HCPR) check completed for Staff A upon hire. -There was no date of hire for Staff A. Interview with Staff A on 07/07/21 at 9:15am revealed: -She had been employed at the facility as a medication aide for greater than one year and the Health and Wellness Director or the Business Office Manager (BOM) completed her HCPR check prior to the first day that she worked. Refer to interview with the Resident Care Coordinator (RCC) on 07/09/21 at 9:55am. Refer to interview with the current BOM on 07/09/21 at 11:15am. Interview with the Executive Director (ED) on 07/09/21 at 12:05pm revealed: -She expected the BOM ensure that staff records were complete. -She did not know that Staff did not have a staff record. -She had not audited staff records since the new BOM started 3 weeks ago. 2. Review of Staff B's, personnel record revealed: -There was no documentation of a Health Care Personal Registry (HCPR) check completed for Staff B upon hire. -There was no date of hire for Staff B.	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 137	Continued From page 19 Interview with Staff B on 07/07/21 at 9:15am revealed: -She was a personal care aide (PCA) employed through a temporary staffing agency. -She was never asked to present her credentials to the facility to verify HCPR status. Telephone interview with a representative from the temporary staffing agency on 07/12/21 at 9:45am revealed: -The agency had been supplying the facility with PCAs since April 2021. -The facility was given access to computer records for the temporary staff that included HCPR status. -The agency had a policy that staff could not have any HCPR findings to be able to work for the agency. -The facility never notified the agency of any difficulty obtaining the credentials for agency staff. Refer to interview with the Resident Care Coordinator (RCC) on 07/09/21 at 9:55am. Refer to interview with the Business Office Manager (BOM) on 07/09/21 at 11:15am. Refer to interview with the Executive Director (ED) on 07/09/21 at 12:05pm. 3. Review of Staff C's, personnel record revealed: -There was no documentation of a Health Care Personal Registry (HCPR) check completed for Staff C upon hire. -There was no date of hire for Staff C. Interview with Staff C on 07/08/21 at 9:00 am revealed: -She was a PCA employed through a temporary	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 137	Continued From page 20	D 137		

staffing agency.
-She was never asked to present her credentials to the facility to verify HCPR status.

Telephone interview with a representative from the temporary staffing agency on 07/12/21 at 9:00am revealed:
-The agency had been contracted by the facility to provide PCAs since January 2021.
-Until approximately two months ago the agency sent a file on their staff to the facility that included staff's information that
could be used to verify HCPR status.
-Two months ago, the agency was informed by the BOM and ED that they no longer needed to send the staff's information.

Refer to interview with the Resident Care Coordinator (RCC) on 07/09/21 at 9:55am.

Refer to interview with the BOM on 07/09/21 at 11:15am.

Refer to interview with the ED on 07/09/21 at 12:05pm.

4. Review of Staff D's, personnel record revealed:
-There was no documentation of a Health Care Personal Registry (HCPR) check completed for Staff D upon hire.
-There was no date of hire for Staff D.

Staff D was not available for interview during the survey.

Telephone interview with a representative from the temporary staffing on 07/12/21 at 1:09pm revealed:
-The agency relied on the ED to request documentation of the HCPR from the agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 137	Continued From page 21 -The facility had not requested any documentation on Staff D. Refer to interview with the Residential Care Coordinator (RCC) on 07/09/21 at 9:55am. Refer to interview with the Business Office Manager (BOM) on 07/09/21 at 11:15am. Refer to interview with the Executive Director (ED) on 07/09/21 at 12:05pm. 5. Review of Staff E's, personnel record revealed: -There was no documentation of a Health Care Personal Registry (HCPR) check completed for Staff E upon hire. -There was no date of hire for Staff D. Staff E was not available for interview during the survey. Telephone interview with a representative from the temporary staffing on 07/12/21 at 1:09pm revealed: -The agency relied on the ED to request documentation of the HCPR from the agency. -The facility had not requested any documentation on Staff E. Refer to interview with the Residential Care Coordinator (RCC) on 07/09/21 at 9:55am. Refer to interview with the Business Office Manager (BOM) on 07/09/21 at 11:15am. Refer to interview with the Executive Director (ED) on 07/09/21 at 12:05pm. _____ Interview with the Resident Care Coordinator (RCC) on 07/09/21 at 9:55am revealed:	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 137	Continued From page 22 -The Executive Director (ED) was responsible to communicating with the temporary staffing agency -She could contact the agency if a last-minute staffing need arose. -She did not print agency staff HCPR because she was never asked to do that. Interview with the Business Office Manager (BOM) on 07/09/21 at 11:15am revealed: -She had been employed as BOM for three weeks. -She knew it was her responsibility to maintain the staff records. -She had not audited the staff records to make sure each staff's HCPR was completed. Interview with the Executive Director (ED) on 07/09/21 at 12:05pm revealed: -She had a verbal agreement with the temporary staffing agency that the staff sent to the facility would have documentation of a completed HCPR check. -She expected the BOM to maintain the staff records and ensure the HCPRs check had been completed. -She had not audited staff records since the BOM started the middle of June 2021.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 139	Continued From page 23	D 139		

facility failed to ensure 5 of 6 sampled staff (Staff A, B, C, D and E) had a criminal background check completed prior to hire.

1. Review of Staff A's, personnel record revealed:
-There was no documentation of a criminal background check completed for Staff A upon hire.
-There was no date of hire for Staff A.

Interview with Staff A on 07/07/21 at 9:15am revealed:
-She had worked at the facility for approximately a year but did not know her date of hire.
-The previous Business Office Manager (BOM) and previous Health and Wellness Director (HWD) completed her criminal background check prior to being hired.
-The BOM and HWD were no longer employed at the facility.

Interview with the current BOM on 07/09/21 at 11:15am revealed:
-When she looked for Staff A's staff record today, she could not find Staff A's personnel record.
-She knew it was her responsibility to maintain the staff records.
-She had not had time to run a criminal background check on Staff A.

Interview with the Executive Director (ED) on 07/09/21 at 12:05pm revealed:
-She expected the BOM to make sure that the personnel records were complete.
-She did not know that Staff A did not have a personnel record or a criminal background check.
-She had not audited staff records since the BOM started in her role the middle of June 2021.

2. Review of Staff B's, personnel record revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 139	Continued From page 24 -There was no documentation of a criminal background check completed for Staff B upon hire. -There was no date of hire for Staff B. Interview with Staff B on 07/07/21 at 10:20am revealed: -She worked for a staffing agency that was contracted by the facility. -She had worked on the Special Care Unit for the past two weeks as needed as a personal care aide (PCA). -She was not asked for her criminal background check when she started two weeks ago. -She thought the staff agency completed her criminal background check, but she was not sure. Refer to interview with the Business Office Manager on 07/09/21 at 11:15am. Refer to interview with the Executive Director on 07/09/21 at 12:05pm. 3. Review of Staff C's, personnel record revealed: -There was no documentation of a criminal background check completed for Staff C upon hire. -There was no date of hire for Staff C. Interview with Staff C on 07/08/21 at 9:26am revealed: -She worked for a staffing agency that was contracted by the facility. -She had worked on the Special Care Unit (SCU) for approximately a month as needed as a personal care aide. -She was not asked to complete a criminal background check when she started working at the facility. -When she was assigned to work at the facility	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 139	Continued From page 25 and went right to the SCU. -She thought the staff agency completed her criminal background check, but she was not sure. Refer to interview with the Business Office Manager on 07/09/21 at 11:15am. Refer to interview with the Executive Director on 07/09/21 at 12:05pm. 4. Review of Staff D's, personnel record revealed: -There was no documentation of a criminal background check completed for Staff D upon hire. -There was no date of hire for Staff D. Staff D was not available for interview during the survey. Refer to interview with the Business Office Manager on 07/09/21 at 11:15am. Refer to interview with the Executive Director on 07/09/21 at 12:05pm. 5. Review of Staff E's, personnel record revealed: -There was no documentation of a criminal background check completed for Staff E upon hire. -There was no date of hire for Staff E. Staff E was not available for interview during the survey. Refer to interview with the Business Office Manager on 07/09/21 at 11:15am. Refer to interview with the Executive Director on 07/09/21 at 12:05pm.	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 139	Continued From page 26 Interview with the Business Office Manager (BOM) on 07/09/21 at 11:15am revealed: -She had been in the BOM position for three weeks and had not received any documents related to temporary agency staff. -She did not know that the facility was required to keep a personnel record on temporary staff. Interview with the Executive Director (ED) on 07/09/21 at 12:05pm revealed: -The facility contracted with three different temporary staffing agencies. -Two of the staffing agencies were contracted prior to her coming to the facility. -She contracted with the third agency that maintained staff credentials through an application on their cellphones. -She had a verbal agreement with the staffing agencies for all agency staff to have the required criminal background check prior to working at the facility. -She expected the BOM to maintain the staff records. -She had not audited staff records since the previous BOM quit last month.	D 139		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	Continued From page 27	D 161		

performing the task and that their ongoing competency is assured through facility staff oversight and supervision.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled staff (Staff A, D, and E) were competency validated for Licensed Health Professional Support (LHPS) tasks including applying and removing TED hose and collecting and testing of fingerstick blood samples (FSBS).

The findings are:

1. Review of Staff A's, medication aide (MA), staff record revealed:
-Staff A did not have a staff record.
-There was no documentation of a LHPS competency validation.
-There was no documentation Staff A completed a Medication Administration Clinical Skills Validation Checklist.

Review of an electronic Medication Administration Record (eMAR) revealed Staff D collected fingerstick blood sugars (FSBS) on 06/01/21, 06/04//21, 06/07/21, 7/02/21, 07/07/21, and 07/08/21.

Observation on 07/07//21 during the medication pass between 9:00am and 10:00am revealed Staff A obtained a FSBS on a resident.

Interview with Staff A on 07/07/21 at 9:15am revealed:
-She was hired over a year ago and worked as a MA in the SCU.
-She was checked off for her LHPS tasks by the LHPS Registered nurse (RN) when she started

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	Continued From page 28 working on the medication cart last year. Refer to interview with the Licensed Health Professional Support (LHPS) Registered nurse (RN) on 07/12/21 at 1:09pm. Refer to the interview with the Business Office Manager on 07/09/21 at 11:15 am Refer to interview with the Executive Director on 07/09/21 at 12:05pm. 2. Review of Staff D's, medication aide (MA), personnel record revealed: -Staff D did not have a staff record. -There was no documentation of a LHPS competency validation. -There was no documentation Staff D completed a Medication Administration Clinical Skills Validation Checklist. Review of an electronic Medication Administration Record (eMAR) revealed Staff D collected fingerstick blood sugars (FSBS) on 06/05/21, 06/06/21, 06/07/21, 06/19/21, 06/20/21, 06/23/21, and 06/24/21. Attempted telephone interview with staff D on 07/12/21 at 9:10am was unsuccessful. Refer to interview with the Licensed Health Professional Support (LHPS) Registered nurse (RN) on 07/12/21 at 1:09pm. Refer to the interview with the Business Office Manager on 07/09/21 at 11:15 am Refer to interview with the Executive Director on 07/09/21 at 12:05pm.	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	Continued From page 29 3. Review of Staff E's, medication aide (MA), personnel record revealed: -Staff E did not have a staff record. -There was no documentation of a LHPS competency validation. -There was no documentation Staff E completed a Medication Administration Clinical Skills Validation Checklist. Review of an electronic Medication Administration Record (eMAR) revealed Staff D collected fingerstick blood sugars (FSBS) on 06/05/21, 06/06/21, 06/09/21, 06/10/21, 06/12/21, 06/13/21, 06/14/21 and 06/15/21. Review of an electronic Medication Administration Record (eMAR) revealed Staff D removed TED hose on 06/05/21, 06/06/21, 06/09/21, 06/10/21, 06/12/21, 06/13/21, 06/14/21 and 06/15/21. Attempted telephone interview with staff D on 07/12/21 at 9:10am was unsuccessful. Refer to interview with the Licensed Health Professional Support (LHPS) Registered nurse (RN) on 07/12/21 at 1:09pm. Refer to the interview with the Business Office Manager on 07/09/21 at 11:15 am Refer to interview with the Executive Director on 07/09/21 at 12:05pm. _____ Interview with the Licensed Health Professional Support (LHPS) Registered Nurse (RN) on 07/12/21 at 1:09pm revealed: -She was not employed through the facility and was contracted through a company. -She and another LHPS RN completed all LHPS check offs for the staff.	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 161	Continued From page 30 -They provided the original copies of LHPS check off lists to the facility but did not keep their own copy on file. -The facility reached out to her on 07/09/21 to request she visit to complete LHPS check offs for staff hired by the facility. -She did not complete LHPS check offs for contracted agency staff because the facility requested, she complete the permanent staff. -She was told the contracted staffing agency made sure all agency staff were nursing assistants (NAs) and did not need anything. Interview with Business Office Manager on 07/09/21 at 11:15am revealed: -It was her responsibility to maintain the staff records. -She had not had a chance to audit the Staff records since she started in her role the middle of June 2021. -She thought staffing agency was responsible for providing LHPS competency validation for their staff. -She did not request documentation of SCU training for the agency staff. Interview with Executive Director on 07/09/21 at 12:05pm revealed: -The BOM was responsible for maintaining the staff records. -She did not know the staff working the SCU did not have any documentation of LHPS competency validations. -The staffing agency was responsible for the orientation and onboarding of their staff. -She had not audited the staff records since the new BOM started last month to determine if all SCU staff had their required LHPS competency validations.	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 161	Continued From page 31 At the conclusion of the survey, the LHPS competency validation form signed by a qualified licensed health professional had not been received for Staff A, D and E.	D 161		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled residents (#2 & #1) had completed tuberculosis (TB) testing upon admission in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #2's current FL2 dated 05/07/21 revealed: -Diagnoses included, dementia, hypertension, hypothyroidism, general debility and convulsions/seizures. -There was no TB information documented on the FL2.	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 234	Continued From page 32	D 234		

Review of Resident #2's Resident Register signature page revealed an admission date of 05/07/21.

Review of Resident #2's record revealed there was no TB testing or screening documented.

Telephone interview with Resident #2's Power of Attorney (POA) on 07/08/21 at 4:00pm revealed:
-Resident #2 was at another assisted living facility in a different state for a few months prior to admission to this facility.
-Resident #2 had a TB test completed there but not a second one.

Telephone interview with the Health and Wellness Director (HWD) on 07/13/21 at 1:19pm revealed the was no TB information available in Resident #2's record, must be misplaced because Resident #2 could not be admitted to the facility without one.

Telephone interview with the Executive Director (ED) on 07/13/21 at 2:30pm revealed:
-Resident #2 had a TB test sent to us prior to admission because she came from another facility.
-She was due to have her second TB test with in the month after admission but was discharged at the family's request 25 days after admission.

2. Review of Resident #1's most recent FL2 dated 05/20/21 revealed:
-Diagnoses included, dementia, hypertension, atrial fibrillation, and anxiety.
-There was no TB information documented on the FL2.

Review of Resident #1's Resident Register revealed an admission date of 04/01/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 234	Continued From page 33 Review of Resident #1's record revealed: -Resident #1 had one documented TB test on 06/30/20. -The TB test was read as negative on 07/03/20. -There was no documentation a second TB test was performed. Interview with the Health and Wellness Director (HWD) on 07/09/21 at 12:19pm revealed: -There was no documentation of a second TB test for Resident #1. -Resident #1 should have received a second TB test but she was unsure if it was done.	D 234		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance for 4 of 5 residents (Residents #3, #4, #7, and #9) including assistance with showers and linen changes weekly and as needed due to an increased level of care (Resident #9), assistance with a walker and gripper socks for safety with ambulation	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 269	Continued From page 34	D 269		

(Resident #4), assistance with oral care and repositioning a bed bound resident (Resident #7), and assistance with toileting, showers and dressing (Resident #3).

The findings are:

1. Review of Resident #7's current FL2 dated 02/03/21 revealed:
-Diagnoses included dementia, mood disorder, and dysuria (pain with urination).
-Resident #7 required personal care assistance with bathing, dressing, grooming, and toileting.
-She was incontinent of bladder.

Review of Resident #7's record on 07/08/21 revealed:
-There was no Care Plan available for review.
-There was no Resident Assessment available for review.

a. Observation of Resident #7 on 07/07/21 between 9:32am and 11:10am and 2:40pm revealed:
-She was lying on her back in bed with her mouth open.
-Her lips were dry and cracked.
-She had 3 upper teeth with brown staining and black buildup on the back side of the teeth.
-All the teeth were brown and had layers of plaque.
-The backside of the bottom teeth were layered with an unidentified black substance.
-Her tongue and the sides of her oral cavity had a thick layer of black residue and yellow crusting.
-The roof of her mouth had a thin yellow coating with patches of reddened skin.
-There was some dried blood around the upper and lower gums.
-In the top drawer of her bureau there were 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 35	D 269		

unopened packages of mouth swabs, ten in each bag.
-There was also a 32 ounce bottle of unopened mouthwash in the drawer.
-Resident #7 was observed on her back in the bed during each observation.

Interview with the medication aide (MA) on 07/07/21 at 9:55am revealed:
-Resident #7 did not like to get out of bed for breakfast.
-She would assist the personal care aides (PCAs) with dressing the resident, changing her brief and transfers.
-Hospice aides came in twice a week to bathe Resident #7, and provide personal care.
-She did not provide oral care to Resident #7.
-The PCAs were supposed to provide oral care to the residents.
-She was aware of the condition of her teeth and oral cavity; the resident was resistant to oral care.
-The PCAs were supposed to document exceptions to personal care tasks.
-She did not go behind the PCAs to ensure their tasks were completed.

Interview with the PCA on 07/07/21 at 10:15am revealed:
-Resident #7 was resistant with oral care.
-She would try to wash the resident's mouth with a face cloth.
-The resident would grimace and pull away if she attempted to brush her teeth.
-She did not know if there were any mouth swabs left by the hospice nurse.
-She had not used any mouth swabs during the resident's oral care.

Interview with a second shift MA on 07/07/21 at 4:20pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 36	D 269		

-Resident #7's mouth had been in poor condition since she moved in to the facility in April, 2021.
-When she ate, her gums would bleed and her teeth were soft and not firmly rooted to the gums.
-She did not want to eat at times because of mouth pain.
-The staff were afraid the loose teeth would fall out during meals and Resident #7 would choke on one of them.
-There were times she observed pus around the base of the teeth and the gumline.
-She did not provide oral care since she passed medications when the residents were receiving their personal care in the evening.
-She did not provide oversight to the PCAs to ensure their assigned tasks were completed.
-The PCAs documented their personal care online and she did not know who reviewed their documentation.
-The Executive Director (ED) and Special Care Manager (SCM) were aware of the condition of the resident's oral cavity.
-She was not given any additional directives from them as to the resident's oral care.

Review of Resident #7's Activities of Daily Living (ADL) log dated 05/01/21 to 07/08/21 revealed there was no documentation Resident #7 received daily oral care.

Review of the Special Care Unit (SCU) communication logs from 05/27/21 to 07/07/21 revealed:
-There was an entry on 05/27/21. "The resident did not eat breakfast or lunch today and only drank very little water."
-There were no other entries regarding Resident #7's mouth pain, non-compliance with oral care or difficulty eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 37 Telephone interview with the hospice Registered Nurse (RN) on 07/08/21 at 11:30am revealed: -Resident #7 was admitted as a hospice client on 05/25/20. -She visited Resident #7 twice a week and provided medication management for anxiety and agitation. -She documented dentition issues upon admission to hospice services. -She brought a total of 70 mouth swabs to the facility for Resident #7 from her admission to the present. -She educated the staff every time she visited on the personal care needs of the resident and the supplies brought for personal care. -She did not think Resident #7 received mouth care aside from the 2 visits for personal care and bathing by the hospice aide. -The extra mouth swabs she delivered were often missing or unopened and facility staff did not report using them during oral care. -The yellow coating on her tongue and the buildup around her teeth indicated she did not receive regular oral care. -The family reported to her Resident #7's personal care, including oral care, was "upsetting to them". -She addressed Resident #7's oral care with the Executive Director (ED) and the Health and Wellness Director (HWD), a Registered nurse (RN) a few weeks ago, who assured her they would address these concerns with the staff. -She told them it appeared from her assessment of her mouth, oral care was not being provided consistently to the resident. -She also reported the oral care supplies and other personal care supplies were missing from her room and the staff did not know where they were. -She reiterated that the mouth swabs she	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 38	D 269		

provided would assist in oral care and be less abrasive than a toothbrush or washcloth.
-She did not see a difference in Resident #7's oral care after the meeting with the ED and HWD.

Interview with the HWD on 07/12/21 at 3:15pm revealed :
-She had recently created a document for the staff to initial on their assignment sheet when the personal care tasks were completed for each resident.
-She was aware Resident #7 had poor dentition.
-Staff reported to her Resident #7 became agitated with oral care.
-She was not aware her oral cavity and teeth were bleeding, covered in a thick black substance and were painful at times.
-She had not reached out to the family or hospice regarding Resident #7's oral care.
-Staff had not reported the extent of the deterioration of her oral cavity and gums or she would have assessed the resident.
-Resident #7 was admitted to the facility before she began her position, and she was told this issue had been ongoing and family was aware.
-The staff had been trained in personal care, including oral care, and were given assignment sheets prior to their shift outlining the specific tasks for each of their residents.
-She did not provide oversite to the PCAs or their staff assignments.
-The Resident Care Coordinator (RCC) distributed and collected the assignment sheets.
-She was not sure if she was responsible for oversite of the PCA tasks.

A request was made for Resident #7's staff assignment sheets, documenting personal care, and was not provided before survey exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 39 Interview with the previous SCM on 07/12/21 at 4:20pm revealed: -Resident #7 had poor oral hygiene and few teeth when she was admitted. -The PCAs were provided with an electronic device, an Activities of Daily Living (ADL) phone, that provided details of the care required for the residents on their assignment sheet. -The nurse entered in the residents information from the most recent assessment into the ADL phone for the PCAs use. -The PCAs documented online through the phone application when the personal care tasks had been completed. -She did not review the PCA logs online. -She did not know if the HWD reviewed the PCA logs online. The PCA ADL phone log for Resident #7 provided by the staff on 07/12/21, from 05/01/21 through 07/09/21, showed no documentation oral care was provided. Interview with the ED on 07/08/21 at 10:05am revealed: -The hospice RN reported Resident #7 was not receiving proper oral care. -She did not assess Resident #7 after this meeting, but relied on the clinical staff to assess the resident. -Due to this report, she implemented a new assignment sheet for PCAs including oral care and nail care protocol. -She directed the clinical staff to review with the PCAs and MAs proper oral care for the residents, and the use of mouth swabs for Resident #7. -The PCAs were to document oral care twice a day on their assignment sheets. -She did not review the PCA logs or the PCAs' assignment sheets.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 40 -She thought the clinical staff reviewed the PCA's ADL logs online and the assignment sheets. -The MAs should ensure the PCAs were completing the ADL's for their assigned residents. -The SCM should be overseeing the MAs and PCAs and ensuring they were performing their assigned tasks, including oral care. b. Observation of Resident #7 on 07/07/21 at 4:30pm revealed: -There was a strong smell of urine in the room. -Resident #7 was lying on her back in her bed, with mouth open and eyes closed. -She was doubled briefed with an incontinence pad underneath her bottom. -She was not soiled but had significant areas of reddish/purple discoloration on her left and right buttocks and above the base of the spine. -The left buttock was almost entirely a darkened red discoloration, with 2 small openings on the top of the buttocks and a nickel size opening on the skin closer to the base of the spine, Interview with a second MA on 07/07/21 at 4:30pm revealed: -She did not know Resident #7 was doubled briefed. -She had seen that occasionally at the facility, but did not know who was double briefing the residents. -She did not know Resident #7 had skin breakdown on her buttocks and lower spine. -She had not been directed by her supervisor or hospice to reposition the resident while in the bed or offload her weight in the wheelchair. -The resident was in the bed most of the time and did not eat or drink. -She had not been informed by the staff there was any discoloration or skin breakdown on Resident #7's buttocks.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 41 -She did not have an order to apply cream or a dressing to the resident's buttocks. Interview with the hospice Registered nurse (RN) on 07/07/21 at 11:45am revealed: -Resident #7 was almost always in the bed or in the wheelchair in her room when she visited her twice a week. -She informed the staff during her visits to the facility to reposition the resident every 2 hours to prevent skin breakdown. -She also reminded staff to change her brief every 2 hours as needed as an intervention to prevent skin breakdown. -The repositioning instructions were given to the MAs and PCAs who were working in the MCU when she visited Resident #7 twice a week. In addition she brought a box of supplies with body wash, mouthwash, briefs, bed pads and wash cloths. -The entire box of supplies were missing at Resident #7's next scheduled visit. -The hospice aide was informed by an employee of the facility that another resident in the Special Care unit (SCU) had diarrhea and Resident #7's supplies were used for them. -The wash basin the hospice aide used for Resident #7's bed baths was also missing. -She was not notified Resident #7 had skin breakdown on her buttocks. -If it had been reported to her she would have prescribed a barrier cream and a dressing over the opened areas. -Communication between hospice and the facility staff was not effective. Interview with the previous Special Care Manager (SCM) on 07/12/21 at 4:20pm revealed: -She had been the SCM until sometime near the end of June 2021.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 269	Continued From page 42 -She had not been informed by the hospice RN that staff should be repositioning Resident #7 every 2 hours when in bed. -She did not have any reports from the staff of the resident's skin breakdown. -If she had, she would have reported the skin breakdown to the hospice nurse. Interview with the HWD on 07/12/21 at 3:15pm revealed : -Hospice was providing oversite for the care of Resident #7 since the end of May. -Resident #7 seemed to have a decline in health the past week and was in the bed more frequently. -It was not reported to her Resident #7 had skin breakdown on her lower back and buttocks. -She had not instructed the staff to reposition residents who were bed bound every 2 hours. -She had not instructed staff to offload resident's weight when sitting in a wheelchair for long periods of time. -She thought hospice may have given the staff and the SCM some instructions regarding the care of their residents. Interview with the ED on 07/08/21 at 10:05am revealed: -Staff should be inspecting the resident's skin when providing personal care and showers. -If there was any skin breakdown, open areas or reddened areas, staff should notify the HWN. -Until very recently, Resident #7 could verbalize any concerns she had. -It had not been reported to her that Resident #7 had any skin breakdown. -Hospice should have been notified by the MA or SCM. -It was not the policy of the facility to double brief residents.	D 269		

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 269	Continued From page 43	D 269		

-Staff were trained not to double brief residents during the first week of orientation, before providing care to the residents.
-Double briefing and incontinence could contribute to skin breakdown.
-It had not been reported to her staff were double briefing incontinent residents.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.

2. Review of Resident #4's record on 07/09/21 revealed:
-There was documentation Resident #4 returned from a rehabilitation facility on 04/09/21 due to a fall resulting in a fractured greater trochanter of the left femur.
-There was no documentation of a current Care Plan due to this significant change.
-There was a primary care physician's (PCP) consultation note dated 04/13/21 for an order for a referral to home health (HH) services due to gait instability and falls, and to make appropriate Durable Medical Equipment (DME) recommendations.
-There were no HH notes documented in the resident's record.

Interview with Resident #4's guardian on 07/13/21 at 10:15am revealed:
-He had been informed by HH when Resident #4 returned from rehabilitation in April 2021 that she needed a to use a walker when ambulating for gait instability and safety.
-He was concerned that he kept finding her walker in her room in the closet,
-The staff were not encouraging her to use the walker when he came to visit.
-He was concerned she may have another fall

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 44	D 269		

with an injury.
-She also did not have shoes and socks on when he visited.
-Staff told him that this was her home and she did not have to wear shoes and socks if she did not want to.
-Due to her recent injury from a fall, he purchased 6 pairs of gripper socks to be placed on her feet.
-Frequently when he visited, she did not have the gripper socks on but other socks he had not purchased.
-Recently he could not find any of the gripper socks he had purchased for her safety in her bureau or in her laundry basket.
-He did not know there had been a change in the Special Care Manager (SCM), or that he could discuss these concerns with her.
-Previously he had been discussing his concerns with the housekeeper because the staff did not seem to be able to answer his questions.

Observation in the SCU on 07/07/21, 07/08/21 and 07/12/21 revealed:
-Resident #4 was ambulating in the hallways of the SCU without the aid of a walker.
-Staff were not reminding the resident to use her walker.
-On 07/13/21, Resident #4's walker was observed in her bedroom in the closet with the door closed.

Interview with the PCA on 07/13/21 at 10:40am revealed she did not know Resident #4 had a walker and was supposed to use it when ambulating.

Interview with the MA on 07/13/21 at 10:45am revealed:
-Resident #4 never used her walker when ambulating.
-She did not think the resident needed it

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 45	D 269		

anymore.
-She was not being seen by HH at this time.
-She did not think she was unsteady when she ambulated.

Interview with the Health and Wellness Director (HWD) on 07/13/21 at 11:40am revealed:
-She was not in this position when Resident #4 returned from rehabilitation.
-There was no documentation in the record of HH visits or recommendations.
-There was no current LHPS or Care Plan indicating Resident #4 ambulated with a walker.
-There was no documentation in the progress notes that Resident #4 ambulated with a walker.
-She was not aware of the recommendation by HH for Resident #4 to ambulate with a walker for safety.
-She did not know Resident #4 had a walker in her closet.

Interview with the Executive Director on 07/12/21 at 4:45pm revealed:
-She did not know Resident #4 had a walker to ambulate.
-She had not seen any HH notes regarding her physical therapy after she returned to the facility from rehabilitation.
-Frequently outside agencies would come into the facility and she was not aware, especially if they did not leave notes in the resident's record.
-She had implemented a sign in sheet for outside agencies and the receptionist was to inform her of their presence.
-In this way, one of the nurses in the clinical team could meet with them and receive documentation of care.
3. Review of Resident #3's current FL2 with no date and signature revealed:
-Diagnoses included Alzheimer's disease,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 46	D 269		

nocturia (frequent urination at night) related to benign prostate hyperplasia, diabetes, and bilateral lower extremity edema.
-Resident #3 required personal care assistance with bathing, dressing, grooming, and toileting.

Review of Resident #3's Care Plan dated 09/03/20 revealed:
-Resident #3 required extensive assistance with toileting.
-Resident #3 required limited assistance with bathing, dressing, and grooming.

Resident #3's weekly shower and laundry schedule was requested on 07/07/21, 07/08/21, and 07/09/21 but was not provided and not posted in the special care unit (SCU) until 07/12/21.

Review of Resident #3's weekly shower and laundry schedule posted on wall in the SCU on 07/12/21 at 4:24pm revealed Resident #3's scheduled shower and laundry days were Saturdays and Wednesdays on third shift.

Review Resident #3's Activities of Daily Living (ADL) dated 05/13/21 to 06/03/21 revealed there was no documentation Resident #3 received a shower.

Review of the SCU communication logs from 06/01/21 to 07/07/21 revealed:
-Resident #3 received a bath on 07/01/21.
-Resident #3 did not refuse any showers or attempts to dress or change his clothes.

Observation of Resident #3 on 07/07/21 (Wednesday) at 8:45am revealed Resident #3 was wearing a white t-shirt, gray sweatpants, white socks, and tennis shoes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 47 Observation of Resident #3 on 07/08/21 (Thursday) between 9:15am and 9:48am revealed: -Resident #3 was asleep in his bed fully dressed in the same clothes he wore (07/07/21) a white t-shirt, gray sweatpants, white socks, and tennis shoes. -When Resident #3 got out of his bed, the sheet covering the mattress of his bed had a large urine stain. Interview with another PCA on 07/08/21 at 9:15am revealed: -She was from a staffing agency. -She was a certified nursing assistant (CNA). -She did not have a password to sign onto Resident #3's ADL log. -She did not know when Resident #3 last had a shower and changed his clothes. -When she arrived at the facility this morning the third shift PCA had left already to go home. -She was told by the medication aide to watch Resident #3 and lock him out of his room because he often urinated on the floor in his room, common areas, and other residents' rooms. -Resident #3 did not ask her to use the bathroom but she had to redirect him to the bathroom in the hall when he made attempts to urinate on the floor. Observation of Resident #3 on 07/09/21 (Friday) at 8:30am revealed: -Resident #3 was sitting in the dining room wearing the same t-shirt, black jogging pants, and socks he wore on 07/07/21 (Wednesday) and 07/08/21 (Thursday). -Resident #3's white t-shirt had food stains, and his white socks that had a dark gray stain on the	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 48 top of his left foot above the tongue of his tennis shoes. Observation of Resident #3 on 07/13/21 between 7:45am and 10:15am revealed: -Resident #3 was asleep in his bed in his room. -Resident #3's floor in his room had a strong urine odor. -Resident #3's floor was wet in two of the corners along the wall. -There was a pile of approximate 10 wet paper towels in one area of urine. -When Resident # 3 vacated his bed, he went to the dining room to eat breakfast. -Resident #3's bed had a wet area on his bed sheet. Interview with the third shift PCA on 07/12/21 at 8:00am revealed: -Resident #3 did not receive a shower or have his linens done this past week (07/07/21-07/12/21). -There were only two staff assigned on third shift and they did not have time to provide a shower and laundry for Resident #3. -It was not reported to first shift or the Special Care Manager (SCM) because they were not there when he ended his shift in the morning. Interview with the first shift medication aide (MA) on 07/07/21 at 10:15am revealed: -She did not know what days Resident #3 was scheduled to get a shower and laundry done because it did not come up on her first shift schedule on the computer to be completed. -Resident #3's ADL's on the computer for first shift were toilet assistance, empty trash in resident's room, and provide snack at 11:00am and 9:00pm. -Until a few days ago there was a resident shower and laundry schedule for the PCAs to follow post	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 49	D 269		

in the medication room and she did not know what happened to it.
-The SCM was responsible for posting the shower and laundry schedule.

Interview with the SCM on 07/08/21 at 10:15am revealed:
-She took the shower and laundry schedule home on 07/03/21 (Saturday) with her to make some changes to it.
-The PCA's were expected to access Resident #3's ADL needs that were on the computer care pad and address all of Resident #3's ADL's including showering, laundry, and linen changes.
-Agency staff were supposed to be assigned with at least one full time staff to be able to receive their orientation to their assignment and document in the communication log when Resident #3 had a shower and laundry done.
-She expected the MAs to document any resident refusal of assistance with any of their ADLs.

Interview with the Executive Director (ED) on 07/12/21 at 4:45pm revealed:
-She did not review the PCA logs or the assignment sheets for Resident #3.
-She thought the clinical staff reviewed the PCAs ADL logs online and the assignment sheets.
-The MAs should ensure the PCAs were completing the ADL's for their assigned residents.
-The SCM should be overseeing the staff and ensuring they are performing their assigned tasks.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.

5. Review of Resident #9's FL2 dated 04/07/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 50 revealed: -Diagnoses included, pulmonary embolism, syncope and collapse, essential hypertension and anxiety disorder. -Resident #9 required personal care assistance with bathing, dressing. -Resident #9 was incontinent of bowel and bladder. Interview with Resident #9 on 07/09/21 at 4:00pm revealed: -She was bedbound since her last fall in April 2021. -She was a 2 person assist with transfers, bathing, dressing and incontinent care and with the staff not able to get assistance with her most of the time she did not receive incontinent care and brief changes but only two times a day. -She was not assisted to the toilet or showers because the staff were in too much of a hurry with her that it caused her pain and increased fear of falling again. -She was not provided a shower because the staff would not have help or take their time to decrease the pain from moving too fast and fear of falling when the staff were in a hurry and not listening to her requests to go slow. -At this point because of the fear and pain she would rather stay in bed than go through all of that pain and fear. -She was not provided incontinent care or toileting every 2 hours. -She was not provided a shower or a bed bath two days a week, maybe a bed bath every 2 weeks. Review of Resident #9's Resident Register revealed an admission date of 03/31/21. Review of Resident #9's Care Plan dated	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 51 06/21/21 revealed she required extensive assistance with bathing, dressing and grooming. a. Review of the facility's weekly shower and laundry schedule for the Assisted Living (AL) revealed: -All residents were listed on the form according to room number and name. -All the residents documented on the form were given two days a week and shift for their baths. -Resident #9 was scheduled for a shower and laundry change on Mondays and Thursdays on first shift. Review of Resident #9's facility Resident General Notes revealed there were no entries related to showers refused. Review of Activities of Daily Living (ADL) log for May 2021 revealed: -Documentation started on 05/13/21. -There were no showers documented. Review of ADL log for June 2021 revealed there were no showers documented. Review of ADL log for July 2021 revealed there were no showers documented. Observation of Resident #9 on 07/07/21 at 9:50am revealed: -She had on a white top with food and food stains on it. -Her breakfast tray was still on the bedside table that was across her abdomen. Observation of Resident #9 on 07/07/21 at 12:00pm revealed she had on a white top with food and food stains on it.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 52 Observation of Resident #9 on 07/07/21 at 2:00pm revealed she had on a white top with food and food stains on it. Observation of Resident #9 on 07/07/21 at 4:00pm revealed she had on a white top with food and food stains on it. Interview with a personal care aide (PCA) on 07/07/21 at 9:46am revealed: -She was from an agency and worked at the facility for a month and a half. -Resident #9 did not receive showers because she was too hard to get up and resisted care. -It took two staff to get her up but when staff attempted to deliver care she was resistant because she was fearful of falling. -She was not sure if Resident #9 received bed baths or not. -There was no where to document the care provided. -She informed the medication aide (MA), Resident Care Coordinator (RCC), Health and Wellness Director (HWD) and the Executive Director (ED) during the first week she worked here about how hard it was to get Resident #9 up and was told by all 4 staff, "that's how she is" and there was nothing they could do about it. Observation of Resident #9 on 07/08/21 at 8:00am revealed: -Her bedside tray table was across her with her breakfast tray on it. -She had on the same white shirt from yesterday (07/07/21) with the same food stains and new food on it. Interview with a second PCA on 07/08/21 at 8:30am revealed: -She worked at the facility for 3 years.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 53 -Resident #9 was not out of the bed that morning because the PCA did not have help so she came down to help. -Resident #9 was a 2 person assist and who was resistant to care when we get her up because she is scared of falling. -Resident #9 received a bed bath if she soiled herself. -She did not know the last time Resident #9 soiled herself. -Resident #9 did not receive showers because she was a 2 person assist and did not always have help because each PCA had their own task to perform each shift. -She had not given Resident #9 a full bed bath since Resident #9 was admitted, but did give a good wipe down during incontinent care with all brief changes. -The PCAs were responsible for documenting all care for the residents in the ADL log and she did not document bed baths because they were not showers. Interview with a third PCA on 07/08/21 at 8:30am revealed: -She worked at the facility since November 2020. -She was providing care for Resident #9 today and needed help from another PCA to provide incontinent care. -Resident #9 was a 2 person assist because of the fear of falling, weakness, and pain. -She provided a full bed bath for Resident #9 that she could recall maybe last month in June 2021. -Resident #9 was on the shower schedule for 2 times a week, on Mondays and Thursdays during first shift. -The MAs, RCC, HWD and the ED were aware Resident #9 required 2 plus assist with all care but just told her "that was the way" Resident #9 was.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 269	Continued From page 54	D 269		

-With staffing only one PCA and MA per floor and other job duties, Resident #9 did not receive the showers as required.
-Resident #9 was easier to provide care for while in bed because of needing 2 staff to get her up and put her back to bed.
-She did not document a bed bath or a shower because she only provided incontinent care not a full bed bath or shower.

Telephone interview with Resident #9's Power of Attorney (POA) on 07/08/21 at 7:20pm revealed Resident #9 required help with showers because of a decline in strength since her last fall in April 2021 and hospitalization.

Telephone interview with the Resident Care Director (RCD) on 07/12/21 at 9:13am revealed:
-Resident #9 was on shower schedule 2 times a week.
-Resident #9 "pulls back" and staff have a hard time with transfers from bed to recliner.
-She expected the staff to administer a bed bath 2 times a week for Resident #9.
-The PCAs were responsible for documenting the bed baths in the ADL log, either on paper or electronically.
-She was not aware Resident #9 was not receiving the 2 bed baths a week.
-She did not check the logs.

Telephone interview with Resident #9's Primary Care Physician (PCP) on 07/12/21 at 11:41am revealed:
-She saw Resident #9 on 06/14/21 was the first time she saw Resident #9.
-Resident #9 was in bed at the time.
-She did not know that Resident #9 was considered bed bound.
-She was not aware Resident #9 did not receive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 269	Continued From page 55	D 269		

bed baths two times a week as per the shower schedule.
-She expected the facility staff to provide showers or bed baths at least two times a week to reduce the risk of pressure sores and skin break down.

Telephone interview with the Health and Wellness Director (HWD) on 07/13/21 at 1:46pm revealed:
-She was a Registered Nurse.
-It was the responsibility of the Assisted Living (AL) staff to perform care for each resident.
-The PCAs were to use the ADL phone to see the task that were to be completed for each resident on each shift, each day.
-The PCAs were to document all tasks completed for each resident.
-A shower schedule was completed and posted in the AL nursing office.
-Each resident was assigned 2 days minimum each week for their showers or baths and was to be documented on the ADL log or form.
-The MAs were responsible for checking the ADL logs for completion.
-The RCD was responsible for auditing the ADL logs weekly for compliance.
-She did not check the ADL logs for completion, because it was the responsibility of the Resident Care Director (RCD).

Telephone interview with the Executive Director (ED) on 07/13/21 at 2:30pm revealed:
-She did not know Resident #9 was not getting showers or bed baths.
-The RCD was responsible for posting the shower schedule monthly and Resident #9 should have received 2 showers a week.
-The PCAs were responsible for giving the showers per the schedule and documenting the task in the ADL log as soon as the task was completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 56	D 269		

-The MAs were responsible for checking behind the PCAs each shift to make sure the tasks were completed.
-The RCD was responsible for checking the ADL logs for completion, refusals or blanks on a least a weekly basis.

b. Observation of Resident #9 on 07/08/21 at 8:30am revealed:
-Resident #9 had small amount of feces that was dried and the skin was wet.
-Resident #9's peri-area and groin were reddened, wet and intact.
-Resident #9's heels and elbows were reddened, dry and intact.
-The PCAs used the wet brief to wipe the dried feces off and applied another brief.
-She came back to assist the other PCA 15 minutes later and provided peri-care along with a new brief.

Review of Resident #9's facility Resident General Notes revealed there were no entries related to Resident #9 refused her brief being changed.

Review of Activities of ADL log for May 2021 revealed assistance with adult briefs were documented 14 times in 31 days, 05/13/21 to 05/31/21.

Review of ADL log for June 2021 revealed assistance with adult briefs were documented 26 times in 30 days, 06/01/21 to 06/30/21.

Review of ADL log for July 2021 revealed assistance with adult briefs were documented 7 times in 7 days, 07/01/21 to 07/07/21.

Interview with a PCA on 07/07/21 at 3:15pm reveled:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 57 -She was agency staff and worked second shift. -The PCAs were to complete rounds and toileting every 2 hours. -She typically could only perform incontinence care for Resident #9 between 2:00pm and 4:00pm each shift she worked and then it was if, the PCA from third floor or the MA could help. -Resident #9 could stay in the bed or recliner from 2:00pm till 7:00pm or after if there was no help from another PCA. -After she finished in the dining room around 6:00pm to 6:30pm, it was her responsibility to get the trays out to the residents who ate in their room including Resident #9. -If Resident #9 was out of bed she would have to wait until around 9:00pm until the third floor PCA could help get Resident #9 back in bed and change her brief. -If the no one could help her then, the second shift MA or third shift staff would have to put Resident #9 back to bed. -Her shift ended at 10:00pm. -She was not instructed to document ADLs any where or at all by the facility staff. -She was trained by her agency to document only things that were wrong. Interview with a second PCA on 07/08/21 at 8:30am revealed: -She used the wet brief to remove some dried feces off of Resident #9. -She put another brief on Resident #9 until the other PCA could get the supplies ready and ensure she had time to help. -Resident #9 was a 2 person assist and was resistant to care when we get her up because she is scared of falling. -The PCAs were responsible for documenting all care for the residents in the ADL log.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 269	Continued From page 58	D 269		

Telephone interview with Resident #9's POA on 07/08/21 at 7:20pm revealed Resident #9 required help with toileting because of a decline in strength since her last fall in April 2021 and hospitalization.

Telephone interview with Resident #9's Primary Care Physician (PCP) on 07/12/21 at 11:41am revealed:
-She saw Resident #9 on 06/14/21 was the first time.
-Resident #9 was in bed at the time.
-She did not know that Resident #9 was considered bed bound.
-She was not aware Resident #9 did not receive regular toileting or brief changes at least every 2 hours.
-She expected the facility staff to change Resident #9's position in bed or in the chair, toilet and keep Resident #9's skin clean and dry by changing Resident #9 briefs when wet, and don't let Resident #9 sit in a soiled or wet brief to reduce the risk of pressure sores, skin break down and urinary tract infections (UTI).

Telephone interview with the Resident Care Director (RCD) on 07/12/21 at 9:13am revealed:
-Resident #9 was bedbound and was to be toileted or incontinent brief changes every 2 hours.
-The PCAs were responsible for documenting the incontinent care and brief change in the ADL log, either on paper or electronically.
-She was not aware Resident #9 was not receiving incontinent care and brief changes every 2 hours.
-She expected the PCAs and MAs on the AL to assist Resident #9 with the every 2 hour toileting/incontinent care and brief changes.
-She did not check the logs or question the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 269	Continued From page 59 related to the every 2 hour rounding/toileting of Resident #9. Telephone interview with the Executive Director (ED) on 07/13/21 at 2:30pm revealed: -She did not know Resident #9 was not receiving assistance with changing her brief at least every 2 hours. -Resident #9 not getting her brief changed every 2 hours and setting in a wet brief could cause a UTI. -The PCAs were responsible for rounding and toileting each resident every 2 hours and documenting the tasks in the ADL log as soon as the task was completed. -The MAs were responsible for checking behind the PCAs each shift to make sure the tasks were completed. -The Resident Care Director (RCD) was responsible for checking the ADL logs for completion, refusals or blanks on a least a weekly basis. Telephone interview with the Health and Wellness Director (HWD) on 07/13/21 at 1:46pm revealed: -She was a Registered Nurse. -It was the responsibility of the Assisted Living (AL) staff to perform care for each resident. -Rounding and toileting was to be completed a minimum of every 2 hours. -The PCAs were to use the ADL phone to see the task that were to be completed for each resident on each shift, each day. -The PCAs were to document all tasks completed for each resident. -The MAs were responsible for checking the ADL logs for completion. -She did not check the ADL logs for completion because it was he RCD's responsibility to audit the ADL logs weekly for compliance.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 269	Continued From page 60 Interview with another PCA on 07/08/21 at 8:30am. -All PCAs were to document brief changes in the ADL phone or forms after the care was provided. -The ADL phone and forms were in the nursing office. -The completed forms from each shift were to be returned to the nursing office and placed in the RCC's mailbox. -The ADL phone was to be returned to the nursing office as well. -The MAs were responsible for checking to make sure all tasks were completed each shift. -The RCC was responsible for checking the ADL form and phone logs for task completions each day. _____ The facility failed to provide personal care assistance for a resident with poor oral hygiene resulting in a thick, black build up around her remaining 8 teeth, leaving the remaining teeth loose and causing her pain and not providing proper incontinence care or repositioning the resident which resulted in discoloration and broken areas of the skin (Resident #7); a dementia resident with a recent injury from a fall who required a walker and proper foot coverings for safety with ambulation (Resident #4), a resident who required assistance with bathing, dressing, and toileting and was not assisted resulting in the resident going without a shower for 21 days, and urinating in the bed and floors (Resident #3); and a resident who had a diagnosis of cerebral palsy and continent of bowel and bladder, being made to wear incontinent undergarments due to staff refusing to take her to the restroom and being made to go to bed earlier than desired (Resident #13). The facility's failure resulted in risk for serious neglect and constitutes	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 269	Continued From page 61 a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on July 8, 2021 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 12, 2021.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 4 of 6 sampled residents related to residents with elopement incidents (#3, #4, #5) and a resident with an order for the Special Care Unit (SCU) who required increased supervision to prevent an elopement and disruptive behaviors (#6). The findings are: Review of the facility's Elopement/Unsupervised Absence Safety Program revealed: -The purpose of the program was to provide a system of identification of residents at risk for	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 270	Continued From page 62	D 270		

unsafe wandering and elopement.
-A proactive program for staff education through drills and in-services.
-Elopement attempts occur when a resident exhibited exit seeking, identified as a risk, required monitoring, attempted to leave a safe area without supervision or not in constant sight.
-Elopement attempts occur when a resident potential for serious injury, required supervision due to confusion or cognitive impairment.
-An action plan was to be completed (no more than 90 days) including identifying risks, measures to correct or improve risks, and staff responsible for corrective measures.

Review of the facility's Resident Elopement Report, elopement risk review revealed:
-If a resident was identified as at risk for eloping, an individualized service plan would be developed and shared with the staff and responsible party.
-Elopement occurred when a resident was exit seeking, required monitoring or attempted to leave a safe area without supervision.
-A wandering and elopement risk review would be performed on all residents prior to or upon move-in, every 6 months or when there were changes in the physical or cognitive status that may lead to elopement and possible serious injury.

1. Review of Resident #5's current FL2 dated 10/06/20 revealed:
-Recommended level of care was domiciliary.
-Diagnoses included dementia.

Review of Resident #5's Resident Register revealed Resident #5 was admitted to the facility on 10/23/20.

Review of Resident #5's faxed provider visit/order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 63	D 270		

form dated 06/27/21 revealed:
-Staff concerns: Resident #5 was found across the street, claiming that she lived there 06/25/21.
-Provider's response was since the facility did not use wander guard please reach out to Resident #5's responsible party (RP) to discuss possible transition to the Special Care Unit (SCU) on 06/29/21.

Observation of the 5-lane road in front of the facility on 07/09/21 from 12:25pm to 12:35pm revealed:
-The front door to the facility was located approximately 55 yards from the edge of the busy road.
-In the first 5 minutes of the observation there were 73 cars, and 1 bus traveling south bound, and there were 56 cars, 1 bus, 1 transfer truck and 1 car going excessively fast traveling north bound.
-In the next 5 minutes of the observation there were 67 cars, and 1 truck traveling south bound and there were 119 cars, 2 buses and 1 truck traveling north bound.

Review of Resident #5's progress notes dated 07/01/21 revealed Resident #5 continued to attempt to leave the facility.

Review of Resident #5's record 07/07/21 revealed no documentation of an elopement assessment.

Observation on 07/07/21 between 12:00pm and 1:30pm revealed:
-Resident #5 was seated in the dining room with two other residents eating her lunch and listening to a live performance of a singer in the front of the dining room.
-Dietary staff served lunch and came and went from the dining room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 64 -There was no other staff that entered the dining room to supervise Resident #5 throughout hour and a half. -There were no staff supervising Resident #5. Observation on 07/07/21 from 2:00pm to 3:00pm revealed: -Resident #5 was seated in the dining room with other residents watching a visitor singing and playing a guitar. -The Activity Director was directing residents to be seated to watch the visiting singer. -The Activity Director did not remain in the dining room with the residents. Observation on 07/12/21 between 10:00am and 2:00pm revealed: -Resident #5 was in the SCU sitting in a chair in the secondary dining room. -Resident #5 went to the exit door looking out the door and attempted to open the door at 11:45am. Interview with Resident #5's family member on 07/12/21 at 2:05pm revealed: -Staff called and told her Resident #5 had been found across the 5-lane road in front of the facility the last week of June 2021 she could not recall the exact date. -Resident #5 thought she was going to church or the bank. -There was meeting with the Executive Director (ED) and the Health and Wellness Director (HWD) after Resident #5 was found about to cross the 5-lane road in front of the facility the second time. -During the meeting she was told Resident #5 was to be put in a day program where she visited the SCU during the day when the front doors to the facility were unlocked. -Staff told her in the evening, when the front	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 65	D 270		

doors of the facility were locked Resident #5 could return to her room on the assisted living (AL).
-She did not know of any plans currently for Resident #5 to move permanently to the SCU.

Interview with the Assisted Living (AL) medication aide (MA) on 07/12/21 at 2:30pm revealed:
-She knew Resident #5 left the facility or attempted to leave the facility twice and crossed the road in front of the facility.
-Resident #5 was gone to the SCU for a day program to keep her from getting out the front door when it was unlocked during first shift.
-She was told today (07/13/21) staff was to make sure when Resident #5 was on the AL to check on her every 15 minutes.

Interview with the SCU MA on 07/09/21 at 10:00am revealed:
-Resident #5 was in a day program the HWD established after Resident #5 was able to get out of the facility and found on the other side of the 5-lane road in front of the facility twice.
-All the residents including Resident #5 in the SCU were checked on at least every two hours when they were not in direct eyesight.
-Resident #5 did not come to the SCU every day.
-Sometimes residents who required more frequent supervision than every two hours were identified, and their names were written on the white board in the medication room.
-Resident #5's name was not written on the white board and she was not told to increase supervision for Resident #5.

Interview with the Special Care Manager on 07/08/21 at 10:45am revealed:
-Resident #5 was started in a day program that involved Resident #5 visit the SCU during first

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 66 shift. -Resident #5 did not visit the SCU every day. -Resident #5 plan after she attempted to elope and was found across the road in front of the facility was to begin transitioning Resident #5 to become a permanent resident in the SCU. Interview with the HWD on 07/12/21 at 2:30pm revealed: -After Resident #5 left and went across the main road in front of an office building and continued to discuss going across the road there was a meeting with Resident #5's family and Resident #5's PCP was contacted. -There was an order to begin planning to transition Resident #5 to the SCU. -Resident #5 was started in a day program to visit the SCU to get aquatinted with the residents and environment. Interview with the ED on 07/09/21 at 4:45pm revealed: -She and the HWD met with Resident #5's family after Resident #5 was reported across the road in front of an office building and continued speaking of leaving per Resident #5's PCP direction on 06/29/21. -All residents were expected to be checked on at least every two hours, but she expected Resident #5 to be watched constantly at least every fifteen minutes. -She did not discuss the need for a 24-hour sitter for Resident #5 with her family to ensure that during her time on the AL she was watched constantly at least every fifteen minutes. 2. Review of Resident #3's current FL2 with no date and signature revealed: -Recommended level of care was special care unit (SCU).	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 67 -Diagnoses included Alzheimer's disease, nocturia (frequent urination at night) related to benign prostate hyperplasia, diabetes, and bilateral lower extremity edema. -Resident #3 required personal care assistance with bathing, dressing, grooming, and toileting. Review of Resident #3's Care Plan dated 09/03/20 revealed: -Resident #3 required extensive assistance with toileting. -Resident #3 required limited assistance with bathing, dressing, and grooming. Review of Resident #3's incident report dated 06/25/21 revealed: -Resident #3 was able to get through security fence with another resident and found in the parking lot. -Resident #3 was not injured. -Under action taken there were options to check included medical review, care plan updated, staff re-education and other. -None of the options under action taken were checked. -The physician, responsibility party, manager, person preparing report, and Executive Director notification lines were left blank. Review of Resident #5's progress notes on 07/08/21 revealed there was no documentation Resident #5 left the SCU and was found in the parking lot. Observation on 07/07/21 between 9:30am and 10:02am revealed: -Dietary staff were observed removing a food service cart out of the SCU through the front entrance door of the SCU leading to the elevator. -Dietary staff left the door ajar and entered a code	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 68	D 270		

into the keypad as she exited the SCU and return inside of the SCU to remove another food service cart.

Observation on 07/07/21 from 2:00pm to 3:00pm revealed:
-Resident #3 was seated in the AL dining room with other residents watching a visitor singing and playing a guitar.
-The Activity Director did not remain in the dining room with Resident #3.
-No staff remained in the AL dining room with the residents.

Telephone interview Resident #3's responsible party (RP) on 07/07/21 at 3:41pm revealed:
-She visited Resident #3 weekly since the first week of June 2021.
-Resident #3 would attempt to leave the SCU when she visited him.
-Resident #3 was not engaged in enough activities so he would continuously walk to the doors of the SCU and attempted to open them.

Interview with the first shift SCU personal care aide (PCA) on 07/08/21 at 10:20am revealed:
-Resident #3 was to be checked on every two hours because he would urinate on the floor and furniture in his room or other residents' rooms.
-She was not told to check on Resident #3 more often than every two hours because Resident #3 attempted to elope.

Interview with the SCU medication aide (MA) on 07/09/21 at 10:00am revealed:
-Resident #3 was indicated as a medium risk for elopement according to his electronic care note like all the residents on the SCU.
-All the residents in the SCU were checked on at least every two hours when they were not in direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 69	D 270		

eyesight.
-Sometimes residents who required more frequent supervision than every two hours were identified, and their names were wrote on the white board in the medication room.
-Resident #3's name was not written on the white board.

Interview with the Activity Director (AD) on 07/12/21 at 3:00pm revealed:
-She brought the SCU/AL residents for activities on the AL side in order to be able to provide an activity to all the residents during a scheduled time.
-She did not have an assistant to help her provide activities to the AL while she provided activities to the SCU residents or vice versa.
-She seated Resident #3 with other SCU along the far wall of the dining room away from the only exit door out of the dining room.
-When MCU listened to the music performance it stimulated them enough that they would not leave their seats, so she did not have to remain in the dining room with the SCU residents.

Interview with the Special Care Manager on 07/08/21 at 10:45am revealed:
-Since she started working in the SCU a couple weeks ago she was not aware Resident #3 was an elopement risk.
-The staff informed her Resident #3 was found in the parking lot with another resident a few weeks ago.
-Residents who were required closer supervision was to be checked on at least every 15 minutes and redirected.
-Staff were not supposed to leave the SCU doors ajar for any reason.
-Staff were expected to check all the doors throughout their shifts to make sure they were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 70	D 270		

closed tightly.
-Since Resident #3 was found outside in the parking lot Resident #3 was not checked on more frequently that every two hours.

Interview with the Executive Director (ED) on 07/13/21 at 2:15pm revealed:
-The residents in the SCU were all to be kept under constant supervision, engaged in activities by the Activity Director and staff to distract them from exit seeking behaviors.
-She always expected the SCU doors to be checked and secured.
-She visited the SCU on at least daily when she was in the facility.
-She had not completed and a plan to address Resident #3's elopement to the parking lot with another resident.
-Since (07/09/21) she re-education the staff on measures to prevent Resident #3 from eloping again.

3. Review of Resident #4's FL2 dated 04/09/21 revealed:
-Diagnoses included dementia with behavioral disturbances, a history of falls and pain management.
-She was documented as ambulatory with wandering behaviors, constantly disoriented and needing assistance with bathing and dressing.

Interview with the medication aide (MA) on 07/08/21 at 9:05am revealed:
-Resident #4 liked to walk around the unit.
-When the door to the outside garden area was unlocked, she would frequently go outside.
-She would stand by the locked doors and gate and express a desire to go home.
-She did not remember seeing Resident #4 attempting to unlock the gate in the garden area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 71	D 270		

before the day she eloped on 06/27/21.
-She had not been informed by management to watch Resident #4 more closely due to exit seeking behaviors.
-All the residents in the Special Care Unit (SCU) needed to be watched more closely due to their dementia.
-Since the day Resident #4 left the unit and was discovered in the parking lot, staff do not leave the door to the garden area unlocked.
-She had not received any additional directives for supervision or interventions in place for Resident #4.

Interview with Resident #4's guardian on 07/13/21 at 10:15am revealed:
-He was notified by the facility Resident #4 had eloped.
-He did not remember who notified him or when.
-He was informed she left the unit but staff had a visual of her at all times.
-That was the only time he had been informed of Resident #4 leaving the unit unsupervised.
-She had been wandering away from their home, which was the reason for her placement.
-He was concerned for her safety.
-He was not informed of any additional interventions that were put in place after the elopement.

Review of Resident #4's record on 07/09/21 revealed the Care Plan dated 10/01/20 documented the resident maintained exit seeking behavior, but was redirectable.

Review of Resident #4's record on 07/08/21 revealed:
-Based on the facilty's policy, the Resident Elopement Report, there was no documentation of an elopement risk review since the admission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 72	D 270		

date of 06/12/20.
-There was no documentation of an individualized service plan developed and shared with the staff and responsible party.
-There was no documentation of Resident #4's elopement on 06/27/21.
-There was no documentation of an assessment of Resident #4 after the elopement per facility policy.
-There was no incident report available to review related to Resident #4's elopement on 06/27/21.

Interview with the personal care aid (PCA) on 07/09/21 at 1:30pm revealed:
-She was not an employee when Resident #4 eloped.
-She had not been advised of any additional supervision or interventions in place for Resident #4.
-The staff were to have eyes on all the residents at all times, or know where they were.

Interview with the Health and Wellness Director (HWD) on 07/13/21 at 11:40am revealed:
-She had not assessed Resident #4 after the elopement from the SCU on 06/27/21.
-She did not know if the physician or one of the other nurses had assessed her.
-She thought a cognitive assessment to determine elopement risk was for assisted living residents.
-SCU residents already had cognitive decline and were in a locked unit for safety and wandering behaviors.
-The staff have been informed to keep eyes on all he residents in the SCU and know their whereabouts at all times.
-No additional interventions were put in place for Resident #4 after she eloped.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 73	D 270		

Interview with the Executive Director (ED) on 07/08/21 at 2:20
-Resident #4 liked to wander in the SCU.
-The door in the SCU leading to the secured garden was left unlocked for residents to have access to the outside area at will.
-She was notified on 06/27/21 that Resident #4 and another resident were able to leave the locked garden area and were walking in the parking lot.
-Resident #4 had apparently struck the mag lock on the gate that secured the garden area which put the electrical unit off line.
-She had not been informed Resident #4 had previously been exit seeking from the unit, this was the first time to her knowledge.
-The mag lock on the gate had to be replaced and the door from the secured unit to the garden was now locked at all times.
-No further interventions had been put in place.
4. Review of Resident #6's FL2 dated 05/21/21 revealed:
-Resident #6's diagnoses included diabetes mellitus type 2, hypertension, dementia, vitamin deficiency, dyslipidemia, and arthritis.
-Resident #6 required domiciliary level of care.
-Resident #6 was ambulatory and there was no documentation of wandering behaviors.

Review of Resident #6's Care Plan dated 02/21/21 revealed:
-Resident #6 had wandering behaviors, exhibited socially disruptive behavior, resisted care, and was verbally abusive.
-Resident #6 was ambulatory with staff assistance or assistive devices.
-Resident #6 was "always disoriented" and had "significant loss of memory" and "must be directed."
-Resident #6 required limited assistance, needing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 74	D 270		

"prompting and reminders with toileting, bathing, dressing, and grooming. She required limited assistance with ambulation with a cane.
-Resident #6 required no assistance with eating or transferring.

Review of Resident #6's additional corporate Care Plan dated 02/22/21 revealed:
-Resident #6 was documented to be difficult to understand, required time to communicate or frequently needs team members to interpret speech or resident is unable to speak and required other methods to communicate.
-Resident #6 was documented "disoriented most of the time, difficult to communicate needs."
-Resident #6 was documented to require cuing to participate in social activities, meals, and/or redirection or may have behaviors that are difficult to redirect.
-Resident #6 had made one or more attempts to leave community.
-There were no interventions or increased supervision documented.

Review of Resident #6's Progress Notes revealed:
-On 03/09/21 at 5:30am, Resident #6 was awake all night going into other resident's rooms.
-She went into one resident's room inside of her closet and woke the resident up while doing so.
-On 03/28/21 at 1:41pm, Resident #6 threw her clothes out of her bedroom into hallway, urinated and defecated in her room.
-On 04/04/21 at 4:20pm, Resident #6 was agitated today. Staff tried to redirect her to go upstairs and sit in the TV area but she refused to go and wanted to remain downstairs near the concierge desk.
-Resident #6 cursed at staff and said she "would kill them." Staff allowed her to calm down and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 75	D 270		

eventually got her to go upstairs. Staff would "continue to monitor" the resident.
-On 04/23/21 10:02pm, it was documented that Resident #6 had bruises on her left arm and she "did not know how they got there."

Review of Resident #6's Physician Visit Form dated 04/14/21 revealed:
-Resident #6 had a current diagnosis of worsening memory.
-The reason for visit was confusion, agitation, urinary and fecal incontinence, worsening Alzheimer's Disease with behavior problems.
-There was an order for Resident #6 to "upgrade to the memory care unit" and to follow-up with neurologist.

Review of physician's office visit documentation dated 04/14/21 revealed:
-Resident #6 was accompanied to the visit by a staff member of the facility.
-Resident #6 had been more agitated lately and even hit someone at the facility with a book recently and had crying spells "on and off.
-She was followed by a neurologist.
-She was incontinent of bladder and bowel and did not use the restroom at all but rather takes her incontinence brief off and "pees and has bowel movements anywhere she desires in the facility.
-Resident #6 was at risk of self-harm and hurting other people in the facility.
-Resident #6 should be in the memory care unit as per the director.
-The physician provided a written order to transition Resident #6 to the Special Care Unit (SCU).

Review of Resident #6's Nursing Notes revealed:
-On 05/13/21, staff attempted to discuss with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 76	D 270		

Resident #6's responsible party about her quality of life and her level of cognition and how she would benefit from the Special Care Unit (SCU).
-On 06/12/21 at 2:13pm, Resident #6 was observed wandering the second floor.
-Staff states she tried to go out the front door. Resident #6 was very confused and agitated and staff reported her being combative during care, noting she would yell and become verbally abusive toward staff.

Review of Resident #6's Progress Notes revealed:
-On 05/26/21, Resident #6 was "not in a good mood" and was anxious, not allowing the medication aide to check her blood sugar.
-On 06/03/21, Resident #6 was very agitated. She was fighting with staff and became aggressive after several attempts staff were finally able to redirect her and get her dressed for the day.
-On 06/15/21, Resident #6 was confused and disturbed other residents by entering their rooms and taking stuff. Staff tried to "put it under control but it was difficult."

Interview with a medication aide (MA) on 07/08/21 at 9:15am revealed:
-Resident #6 was confused and combative.
-When Resident #6 decided she wanted to go out of the front door, she was always very determined to do so.
-She liked to be near the concierge desk.
-Staff would lock the main entrance door to the facility to prevent Resident #6 from attempting to leave the facility.
-Resident #6 had never successfully attempted to leave the facility that she was aware of.
-Resident #6 would wander in and out of other resident's room and common areas "all the time" and take things.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 77	D 270		

-Staff would try to watch her, keep her busy but if they had to go into a resident's room or other area of the facility where she was not permitted, she would become very upset.
-Staff would attempt to redirect her by giving her activities or tasks to do such as folding her laundry, which sometimes helped calm her down.
-She had asked the former Resident Care Director (RCD) if one-on-one supervision could be added for Resident #6 but she was told this would not be possible and that the family was not open to moving her to the SCU.

Interview with a second MA on 07/08/21 at 10:23am revealed:
-Resident #6 was "constantly confused" and had been going to the SCU sometimes during the day for increased supervision.
-Staff would try to get her to go to the SCU on when there were move-ins or move-outs, or other visitors coming and going, so that she would be less likely to exit of the main entrance.
-If she was not able to go the SCU for some reason, staff would lock the main entrance to the facility.

Interview with a third MA on 07/08/21 at 10:30am revealed:
-Resident #6 was very confused and combative.
-Resident #6 liked to be helpful and staff would give her small tasks to keep her busy sometimes throughout the day.
-She would wander in and out of other resident's rooms throughout the day and night.
-She often would wander into the room that was in the same location on the floor below hers, mistaking it for her room, which would upset the resident who lived in that room.
-She was not aware of her ever leaving the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 78	D 270		

-Staff were told that they could not have 1-on-1 care for Resident #6, so they would just "watch her as much as the could" but had to leave her unsupervised when they had to go into a resident's room to provide care or administer medications.
-When she had to leave Resident #6 unsupervised, she would give her a snack and assist her to sit on a couch in the common area, where she would usually stay until the staff member returned.
-Sometimes she would get really upset when staff had to leave her alone.

Observation of Resident #6 on 07/08/21 at 2:00pm revealed she was in the SCU, sitting in the common area watching television with other residents.

Observation of Resident #6 on 07/09/21 at 4:35pm revealed she was in the assisted living portion of the facility, at the top of the stairs on the 3rd floor foyer, yelling and screaming at staff.

Interview with PCA on 07/09/21 at 4:40pm revealed:
-Resident #6 often became upset and combative and would sometimes yell.
-Resident #6 had been downstairs in the special care unit for the day, but it was time for her to return the assisted living side of the facility and to have her blood pressure checked, which upset her and caused the outburst.
-Resident #6 returned to the assisted living side of the facility for the evening and night each day.

Observation of Resident #6 on 07/12/21 between 8:30am and 9:10am revealed:
-Resident #6 was wandering around the AL second floor around common areas and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 79	D 270		

concierge desk without supervision.
-At 9:06am a staff member approached and was able to take Resident #6 by the hand and lead her down the hallway away from the main entrance area of the assisted living part of the building.

Observation of Resident #6 on 07/13/21 at 8:45am revealed:
-Resident #6 was observed going into the SCU with a PCA from the 3rd floor.
-She was very agitated and was yelling and attempting to hit staff.
-Resident #6's shirt sleeve was torn on the inside of her arm.

Observation of Resident #6 on 07/13/21 at 9:05am revealed:
-Resident #6 returned to the assisted living side of the facility and told the aide that was with her "I'm not going anywhere you are going."

Interview with a PCA on 07/13/21 at 10:55am revealed:
-She was told by the third floor MA to take Resident #6 down to the SCU so she could have more supervision because the main entrance doors to the facility could not be locked.
-As soon as she got her down to the SCU and Resident #6 saw the locked doors to the SCU, she became very combative and became really upset.
-When she got her to the SCU, she was told to take her back to the assisted living side of the facility because she was not allowed to be there, so she brought her back to the assisted living side of the facility and was now keeping a close eye on her.
-She did not know the reason Resident #6 was not allowed in the SCU, just that she was told to return Resident #6 back to the AL side.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 80 Interview with Resident #6's responsible party on 07/13/21 at 10:49am revealed: -Resident #6 had experienced increased confusion and agitation over the past several months, and she was having more difficulty communicating. -She spoke with the Executive Director (ED) on a few occasions regarding moving Resident #6 to the SCU. -She was not able to attend the physician's visit on 04/14/21 and did not realize the physician had written an order for Resident #6 to move to the SCU. -The former RCD had told her Resident #6 had attempted to leave the facility before and she was starting to have conversations about her moving to SCU before that RCD left the facility several months ago. -She was not open to Resident #6 moving to SCU until the facility was able to have visitors again because she wanted to see the room before agreeing to the move and to be able to help Resident #6 get settled in her new room. -She was not aware of any additional supervision measures the facility had in place to assure Resident #6's safety until she was moved to the SCU. Review of NC Department of Health and Human Services Guidance for Visitation and Quarantine in Long Term Care Facilities dated May 5, 2021 revealed facilities should allow responsible indoor visitation at all times and for all residents, regardless of vaccination status of the resident or visitor, unless certain scenarios exist, including; Unvaccinated residents if the COVID-19 county positivity rate is > 10% AND <70% of residents in the facility are fully vaccinated; Residents with confirmed COVID-19 infection, whether	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 81	D 270		

vaccinated or unvaccinated until they have met the criteria to discontinue transmission-based precautions; or Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.

Interview with RCD on 07/12/21 at 2:00pm revealed:
-Resident #6 resided on the AL side of the facility and had a tendency to wander throughout the facility.
-Staff were supposed to be keeping an eye on Resident #6 "at all times."
-Resident #6 had recently started going to the SCU during the day for increased supervision.
-She was not aware that Resident #6 had been wandering into other resident's rooms at night and was not sure how staff could address this issue.

Interview with ED on 07/08/21 at 3:00pm revealed:
-Staff had several care plan meetings with the Resident #6's RP regarding her need for increased supervision and the benefits of moving to special care but the family had not been receptive to the idea of her being moved.
-She spoke with Resident #6's RP about providing a private sitter but they refused to do so.
-She also spoke with Resident #6's RP about the move and was waiting on the RP to visit the room in SCU and to provide a twin size bed because the queen size bed in Resident #6's room would not fit in the SCU companion room.
-Resident #6's physician had written an order in April 2021 for her to be moved to the special care unit.
-She was not aware of Resident #6 ever attempting to leave the facility or of staff locking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 82 to main doors due to her exit seeking behavior. -Resident #6 was very insecure and would often "latch on" to her or other staff members, which they tried to allow her to do in order to keep her from becoming upset. -Staff tried to engage her in activities to keep her from wandering within the facility. -In May 2021, the Health and Wellness Director (HWD) told staff that Resident #6 must be "constantly monitored." -Staff should have been communicating amongst themselves when they had to provide personal care to other residents to assure that someone was always watching Resident #6. Based on observation, interviews and record reviews it was determined Resident #6 was not interviewable. _____ The facility failed to provide supervision for 2 of 3 sampled residents (Resident #3 and #4) residing in the Special Care Unit (SCU), who eloped from the SCU and were found in the parking lot of the facility; a resident who resided in the Assisted Living (AL), with wandering behaviors, exited the facility and crossed a busy 5 lane road in front of the facility with the intentions to go to her home and bank (Resident #5); and a resident in the Assisted Living (AL) facility who had a signed physician's order to be placed in the SCU since April of 2021, who required increased supervision, and continued to reside in the AL with behaviors unsafe to herself, staff and other residents with exit seeking, wandering and behaviors which were disruptive to other residents (Resident #6). The facility's failure resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 83 accordance with G.S. 131D-34 on 07/08/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 12, 2021.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and resident reviews, the facility failed to meet the health care needs for 5 of 7 residents (#1,#2, #5, #13 & #18) in a regard to a resident complaining of respiratory symptoms and a referral to the hospital after a fall, (#2), a resident with a referral to a cardiologist (#5), a resident with ongoing mouth pain (#1), a resident missing an order for a blood thinner (#18), and an order to change the frequency of a laxative (#13). The findings are: 1. Review of Resident #2's current FL2 dated 05/07/21 revealed diagnoses included, dementia, hypertension, hypothyroidism, general debility and convulsions/seizures. Review of Resident #2's Resident Register revealed an admission date of 05/07/21. a. Review of Resident #2's physician order dated	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 84 06/01/21 revealed Zyrtec 10mg every day as needed for allergies. Review of an email from Resident #2's Power of Attorney (POA) to the previous Special Care Manager (SCM) dated 05/24/21 revealed the POA, just spoke to Resident #2 and Resident #2's allergies were bad, and requested the previous SCM order some medications. -She offered to bring in medications for Resident #2. Review of a response email from the previous SCM to Resident #2's POA dated 05/24/21 revealed the previous SCM would inform the medication aide (MA) to reach out to the physician to get an order. Review of an a response email from Resident #2's physician to Resident #2's POA dated 05/27/21 revealed the physician was not contacted by the facility and the physician was not informed of Resident #2's symptoms and the need for allergy treatment. Interview with the Health and Wellness Director (HWD) on 07/09/21 at 3:45pm revealed: -She was a Registered Nurse. -Resident #2 was admitted before she started at the facility. -Resident #2 was sent to the hospital a day or two after she started working at the facility. -It was her understanding from the previous SCM and Resident #2's record, Resident #2 did not have a primary physician yet because of insurance issues with the facility's contracted physician. -When residents did not have a primary care physician, the MAs and previous SCM were supposed to refer Resident #2 to the hospital in	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 273	Continued From page 85	D 273		

order to have a physician evaluate them for any concerns.
-She was not aware Resident #2 was having allergy symptoms.
-Resident #2 did not have a physician so if Resident #2 needed any medications because of allergies, then Resident #2 should be sent to the hospital for evaluation by a physician.
-She was not aware Resident #2 did not go to the hospital for evaluation of the allergy/cold symptoms.
-The MAs and previous SCM were responsible for notifying the POA of any symptoms Resident #2 was having.

Interview with the Executive Director (ED) on 07/09/21 at 3:45pm revealed:
-On 05/31/21, Resident #2 was sent to the hospital at the request of Resident #2's POA.
-It was her understanding from the HWD, Resident #2 did not have a primary physician yet because of insurance issues with the facility contracted physician.
-She was not aware Resident #2 was not sent to the hospital for evaluation after Resident #2 or the POA complained of any symptoms of allergies or cold but was aware that Resident #2 was sent to the hospital on 05/31/21 at the POA's request.
-The MA or the previous SCM was responsible for sending Resident #2 to the hospital so a physician could evaluate Resident #2 instead of Resident#2's POA telling the MAs and previous SCM to do so.
-The MAs and the SCM were also responsible for notifying the POA about any medical concerns or if Resident #2 was sent to the hospital.

Telephone interview with the previous previous SCM on 07/13/21 at 3:36pm revealed:
-She was not sure if Resident #2 had seen the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 86	D 273		

contracted facility physician.
-She did not remember an email from Resident #2's POA related to any concerns of allergies or cold symptoms.
-If she had received an email related to Resident #2's cold or allergy symptoms, she would have forward the email to the nurse or MAs so they could follow up with the physician.
-The MAs were responsible to notify the physician with all concerns related to Resident #2.
-She did not check behind the MAs to see if a physician was notified because it was their job to handle it or to notify her if there were any concerns.
-She instructed the MA to bring Resident #2 to the front so Resident #2's POA could see Resident #2.
-On 05/31/21, Resident #2's POA showed up at the facility and demanded that Resident #2 be transported to the hospital because Resident #2 was complaining of itchy watery eyes and a cough and Resident #2 had strong smelling urine when the POA assisted Resident #2 to the bathroom.
-She observed Resident #2 in the wheelchair with Resident #2's POA and saw a swollen foot without bleeding and did not see any "outstanding concerns".
-She instructed the MA to call 911 to send Resident #2 to the hospital as requested by Resident #2's POA.

Telephone interview with Resident #2's Primary Care Physician (PCP) on 07/13/21 at 2:00pm revealed:
-She saw Resident #2 for an initial visit as a new resident on 05/18/21.
-She was not able to get a full history on Resident #2 because the file was not very detailed and the staff did not assist with the interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 87 -Resident #2's POA was not with Resident #2 during her visit. -She saw the medications ordered by Resident #2's previous PCP and would continued with the medications. -The staff informed her Resident #2 had medications on hand and did not need refill. -She informed the staff to notify her if with any concerns. -She did not receive notification from the facility related to the need for allergy medications, issues with Resident #2 related to cough or the concerns of Resident #2's POA. -She received an email from Resident #2's POA with the concerns of Resident #2 not receiving the medication that was requested by Resident #2's POA as well as the concerns the POA had about Resident #2. -She expected the facility staff to notify her with all medication concerns, any concerns related to Resident #2 or concerns from Resident #2's POA and not informed by Resident #2's POA. Telephone interview with Resident #2's POA on 07/08/21 at 4:00pm revealed: -Resident #2 moved into the facility on 05/07/21. -Resident #2 complained on several occasions from 05/22/21 to 05/24/21 about having itchy watery eyes, swollen eyes and cough. -During the telephone conversations with Resident #2 from 05/22/21 to 05/24/21, Resident #2 sounded like she had a cold or bad allergies, cough and congested. -On 05/24/21, she contacted the MA on duty and reported Resident #2's cough, congestion and itchy watery eyes. -The MA said she would report it to the SCM. -On 05/24/21, after not hearing back form the facility staff, she emailed the previous SCM with concerns about Resident #2's allergies were bad	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 88	D 273		

and asked if some allergy medication could be ordered or could there be some delivered to the facility by family since Resident #2 had a history of allergies.
-She received a reply from the previous SCM and she was told the previous SCM would have the MA to reach out to the physician about the allergy medication orders.
-She did not receive a phone call from the MA or the previous SCM the call to the physician was made.
-After several telephone conversations with Resident #2, and no response or update from the facility staff, on 05/27/21, she emailed the physician on the patient portal and requested an allergy medication for Resident #2 because Resident #2 complained of itchy and watery eyes, swollen eyes, and cough.
-On 05/27/21, the physician emailed her back stating that no one had brought the symptoms Resident #2 was experiencing or the request for medications while she was in the facility on 05/25/21.
-On 05/31/21, after multiple phone calls from Resident #2 with complaints about itchy and watery eyes and cough, a telephone call to the facility, multiple emails to the SCM and ED, and no resolutions, she felt Resident #2 was so badly neglected, she had to go to the facility and take Resident #2 to the hospital.
-Upon arrival to the facility, Resident #2 presented with lower extremity edema, weakness, fall and respiratory symptoms.
-When she assisted Resident #2 to the bathroom, Resident #2 had strong smelling urine.
-Because Resident #2 was complaining of itchy watery eyes, cough, and had the strong smelling urine, she demanded the MA call for an ambulance because she could not get Resident #2 in the car herself and Resident #2 needed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 89	D 273		

be seen by a doctor immediately.
-She expected the facility to notify the physician while the physician was in the facility on 05/25/21 about the symptoms Resident #2 was experiencing in order for the physician to evaluate Resident #2 while the physician was in the facility instead of waiting on her to call the physician herself.
-The MA was reluctant to contact 911 and it took the Emergency Medical Service (EMS) 90 minutes to arrive.

b. Review of an email from Resident #2's POA to the Executive Director (ED) dated 05/24/21 revealed The POA was informed about Resident #2 falling over the past weekend, 05/22/21 to 05/23/21 and no one contacted her.

Review of a response email from the ED to Resident #2's POA dated 05/24/21 revealed an apology from the ED and the ED copied the previous SCM to set an in person meeting to discuss concerns.

Review of an a email from Resident #2's POA to the previous Special Care Manager (SCM) dated 05/24/21 revealed the POA informed the SCM Resident #2 told her this morning that Resident #2 fell again and had some soreness in her elbows and could someone check on Resident #2.

Telephone interview with Resident #2's POA on 07/08/21 at 4:00pm revealed:
-Resident #2 moved into the facility on 05/07/21.
-Resident #2 required assistance with Activities of Daily Living (ADL).
-She emailed the Executive Director (ED) on 05/24/21 with concerns about Resident #2 falling over the past weekend, 05/22/21 to 05/23/21 after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 90	D 273		

a telephone conversations with Resident #2 over the weekend.
-On 05/24/21, she received an email from the ED with an apology for the concerns and the ED copied the previous SCM to set a meeting to address the concerns.
-After the 05/24/21, emails there was no meeting to discuss Resident #2's fall because on 05/21/21 she had the facility send Resident #2 to the hospital for an evaluation from injuries sustained from the falls.
-On 05/31/21, after multiple phone calls from Resident #2 with complaints about pain and other medical concerns, she went to the facility and based on her observation of Resident #2's facial abrasions, swollen eyes, left big toe nail lifted up with dried blood on it, swollen feet and ankles, abrasions to the right shoulder, strong smelling urine and Resident #2 complaining of pain, she demanded the MA call for an ambulance because she could not get Resident #2 in the car herself and Resident #2 needed to be seen by a doctor immediately.
-She expected the facility to notify the physician while the physician was in the facility on 05/25/21 about the falls Resident #2 was experiencing in order for the physician to evaluate Resident #2 while the physician was in the facility and notify the physician with any falls instead of waiting on her to come to the facility and demand the staff send Resident #2 to the hospital for evaluation.

Review of Resident #2's Incident and Accident Report dated 05/26/21 revealed:
-Resident #2 had an unwitnessed fall at 9:30am.
-Resident #2 was observed in the floor in her bedroom.
-Staff found Resident #2 on the floor in her room on her left side.
-Resident #2 stated she was trying to go to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 91	D 273		

bathroom.
-There were no apparent injuries documented.
-The vital signs were documented as blood pressure of 174/92, heart rate 71, respiratory rate 17 pain 6 out of 10 on pain scale, temperature of 98.0, and oxygen status of 96% on room air.
-The physician was notified via fax at 11:03am.
-The family member was notified at 11:30am.

Review of the facility's "Hot Rack" Charting log dated 05/28/21 revealed:
-Resident #2 was documented as hitting her big toe, bled a little, cleaned, applied antibiotic ointment and bandaid.
-There was no documentation about a fall.

Review of the facility's May 2021 Communication Log revealed:
-On 05/31/21, Resident #2's family "demanded" that she send Resident #2 to the hospital to have her checked out due to fall on 05/24/21 documented.
-There was no other documentation related to any other falls.

Review of the Facility's Progress Notes dated 05/26/21 revealed:
-Resident #2 was found on the floor this morning.
-Resident stated she was trying to go to the restroom.
-There was no documentation of injuries.

Review of Resident #2's Emergency Department (ED) visit notes dated 05/31/21 revealed:
-Resident #2 presented to the ED with complaints of weakness for one week, left foot pain, fall yesterday on 05/30/21 and possibly overnight, last night 05/30/21 into 05/31/21, abrasion to left cheek, right shoulder, and bilateral leg swelling.
-Resident #2's review of systems documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 92	D 273		

Resident #2 was positive for fatigue, cough, leg swelling, gait problems and weakness.
-Resident #2's left great toe nail was somewhat loose and and dried blood was noted.
-Resident #2's bilateral extremities had pitting edema.
-Resident #2's urinalysis documented the urine protein was 20mg/dl (an indicator for kidney dysfunction, normal was negative), urine blood was 0.03mg/dl (an indicator of trauma to the kidney, normal was negative), urine leukocytes esterase was 500Leu/mcL (normal was negative), and a white blood count 33 (H) (an indicator of a urinary tract infection (UTI), normal was <=2/HPF).
-Resident #2's Brain Natriuretic Peptide (BNP, a test used to determine congestive heart failure) was 390 (H) (normal was <300pg/mL).
-Resident #2 was admitted to the hospital with acute cystitis without hematuria, weakness, traumatic avulsion (a pulling or tearing away) of the nail plate of toe and late onset Alzheimer's dementia.

Review of Resident #2's Hospitalist notes dated 06/01/21 revealed:
-Resident #2 was admitted on 05/31/21 and discharged to a rehabilitation facility on 06/04/21.
-The active diagnoses were a urinary tract infection (UTI), weakness, and traumatic avulsion of the nail plate of toe.
-Resident #2 was treated an intravenous (IV) antibiotic to treat the UTI, and speech evaluation for the excessive cough to evaluate Resident #2's swallowing, a pain medication for toe nail avulsion and dressing changes with a triple antibiotic ointment, and an arterial doppler to evaluate bilateral extremity arterial insufficiency.

Interview with the Health and Wellness Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 93 (HWD) on 07/09/21 at 3:45pm revealed: -She was a Registered Nurse. -Resident #2 was admitted before she started at the facility. -Resident #2 was sent to the hospital a day or two after she started working at the facility. -It was her understanding Resident #2 did not have a primary physician yet because of insurance issues with the facility contracted physician. -She was not aware Resident #2 did not go to the hospital after falls. -In cases of residents without a primary physician, the MAs and previous SCM were supposed to refer Resident #2 to the hospital for falls in order to have a physician evaluate them. -The MAs and SCM was responsible for notifying the POA of all falls. Interview with the Executive Director (ED) on 07/09/21 at 3:45pm revealed: -On 05/31/21, Resident #2 was sent to the hospital at the request of Resident #2's POA. -It was her understanding from the HWD, Resident #2 did not have a primary physician yet because of insurance issues with the facility contracted physician. -She was not aware Resident #2 was not sent to the hospital for evaluation. -After each fall if Resident #2 complained of any pain or if the POA had concerns, the resident should have been sent to the hospital instead of Resident #2's POA telling the MAs and previous SCM to do so. -The MA or the previous SCM was responsible for sending Resident #2 to the hospital after a fall with injuries and or pain so a physician could evaluate Resident #2. -The MAs and the previous SCM were also responsible for notifying the POA about all falls	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 94 and filling out an incident report on all falls. Telephone interview with Resident #2's Primary Care Physician (PCP) on 07/13/21 at 2:00pm revealed: -She saw Resident #2 for an initial visit as a new resident on 05/18/21. -She was not able to get a full history on Resident #2 because the file was not very detailed and the staff did not assist with the interview. -Resident #2's POA was not with Resident #2 during her visit. -She was not notified about Resident #2's fall and hospitalization. -She expected the staff to inform her of any falls and hospitalizations related to Resident #2. Telephone interview with the previous SCM on 07/13/21 at 3:36pm revealed: -She was not sure if Resident #2 was seen by the contracted facility physician. -She was aware of a fall on 05/26/21 and Resident #2 was not sent to the hospital because there were no injuries reported on the incident report. -The MAs were responsible to notify the physician with all concerns related to Resident #2. -She did not check behind the MAs to see if a physician was notified because it was their job to handle it. -She did not go back and check if the MA notified the physician because she expected the MA to notify her if there were any concerns. -On 05/31/21, Resident #2's POA showed up at the facility and demanded that Resident #2 be transported to the hospital. -She instructed the MA to bring Resident #2 to the front so Resident #8's POA could see Resident #2. -She observed Resident #2 in the wheelchair with	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 95	D 273		

Resident #2's POA and saw a swollen foot without bleeding and did not see any "outstanding concerns".
-She instructed the MA to call 911 to send Resident #2 to the hospital as requested by Resident #2's POA.
2. Review of Resident #5's current FL2 dated 10/06/20 revealed diagnoses included dementia, pacemaker, hyperlipidemia, and hypertension.

Review of Resident #5's Resident Register revealed Resident #5 was admitted to the facility on 10/23/20.

Review of a face-to-face primary care provider (PCP) encounter for Resident #5 dated 01/27/21 revealed the resident's clinical note directive included to schedule appointment with cardiologist for interrogation of pacemaker and for evaluation for continuation of Coumadin (a blood thinner used to treat and prevent blood clots).

Review of a face-to-face PCP encounter for Resident #5 dated 05/18/21 revealed the resident's clinical note directive included resident was unable to prove insight into cardiac history or former cardiologist and referred the resident to a cardiologist to establish care for management of pacemaker and continuation of Coumadin.

Review of Resident #5's record on 07/08/21 revealed:
-There was no documentation of a scheduled cardiologist appointment.
-There was no documentation for a face-to-face encounter note with Resident #5's cardiologist.

Telephone interview with Resident #5's responsible party (RP) on 07/08/21 at 11:10am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 96	D 273		

revealed:
-Resident #5 was seen by a cardiologist before she was admitted to the facility in October 2020.
-He did not know Resident #5 was not seen by a cardiologist since she was admitted to the facility.

Interview with the Resident Care Director (RCD) on 07/09/21 at 10:30am revealed:
-The previous Health and Wellness Director was responsible for ensuring Resident #5 saw a cardiologist.
-She did not know until today (07/09/21) that Resident #5 needed to see a cardiologist.
-When new referrals were ordered for the residents, they were supposed to flagged in the resident's record by the person filing in the resident's record.
-The residents' records with referrals flagged were placed in a rack in the medication room so she could follow up on them.
-Since the Health and Wellness Director (HWD) left the end of May 2021 she was attempting to look at the residents records for missed referrals to follow up on them but she had not had enough time to get to Resident #5's record.

Telephone interview with Resident #3's PCP on 07/08/21 at 3:45pm revealed:
-She began seeing Resident #3 sometime in May 2021 as a new patient when her previous PCP left the practice.
-She wrote the referral (05/18/21) for Resident #5 to see a cardiologist in order to manage her pacemaker and Coumadin because cardiology was not her specialty.
-She expected to be made aware if the staff were not able to get Resident #5's an appointment to see a cardiologist.
-Resident #5 needed to be established with a cardiologist to determine if her pacemaker was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 97	D 273		

working effectively and receive ongoing pacemaker checks that a cardiologist orders every 3 to 6 months.
-If Resident #5's pacemaker was not working effectively it could lead to complications that could be as serious as a dysrhythmia (an abnormal heart rhythm) or heart failure.
-She did not know Resident #5 was not being seen by a cardiologist until today (07/08/21).

Interview with the HWD on 07/09/21 at 10:45am revealed:
-She was a corporate quality assurance nurse and arrived at the facility the middle of May 2021.
-She was fulfilling the job responsibilities of the HWD since the previous HWD resigned the end of May 2021.
-Over the last two months she was working with some agency nurses to audit Resident #3's.
-She did not know Resident #3 had a referral to see a cardiologist until today (07/09/21) because it was overlooked.

Interview with the Executive Director (ED) on 07/12/21 at 4:46pm revealed:
-She did not know Resident #5 was not being seen by a cardiologist for her coumadin and pacemaker.
-She did not know Resident #5 had a referral to be seen by a cardiologist.
-She depended on the HWD to provide the oversight necessary to make sure PCPs were aware of changes any of the residents experienced.
-The HWD resigned after the corporate quality assurance team arrived on site in the end of May 2021.
-The corporate quality assurance nurse was onsite working in the role of the HWD along with agency nurses to audit Resident #5's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 98 3. Review of Resident #1's most recent FL2 dated 05/20/21 revealed diagnoses included hypertension, dementia and anxiety. Review of a facility fax cover sheet dated 05/11/21 revealed: -The cover sheet was sent to Resident #1's Primary Care Provider (PCP). -Resident #1 was complaining of mouth pain. -Staff had administered acetaminophen but it had not helped. -The family was requesting Resident #1's PCP to see her immediately. Review of a PCP progress note for Resident #1 dated 05/14/21 revealed no documentation Resident #1 complained of mouth pain. Review of a signed physician order dated 05/17/21 revealed Resident #1 was prescribed magic mouthwash, 5ml, swish and spit every 8 hours as needed for throat and mouth pain. Review of Resident #1's May 2021 electronic medication administration record (eMAR) revealed: -There was an entry for magic mouthwash (a mouthwash that contains an anesthetic to treat pain), 5ml, swish and spit three times daily as needed for pain. -There was no documentation the medication had been administered. Interview with a representative from the facility's contracted pharmacy revealed magic mouthwash, 450ml, was dispensed for Resident #1 on 05/17/21. Interview with Resident #1's family member on	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 99	D 273		

07/09/21 at 11:41am revealed:
-Resident #1 complained of mouth pain on 05/08/21 and a medication aide (MA) told the family member they were administering tylenol for the pain.
-Resident #1 continued to complain of mouth pain and the family member was told by facility staff she would be seen by the PCP on 05/11/21.
-On 05/12/21, Resident #1's family member was informed Resident #1 had not been seen by the PCP the previous day.
-Resident #1's family member called the PCP on 05/12/21 and was informed the resident was not on the list to be seen the previous day.
-The family member then requested Resident #1 be seen by the PCP as soon as possible for the mouth pain.

Interview with a provider with Resident #1's PCP office on 07/12/21 at 10:53am revealed:
-Resident #1 was seen by another provider from the office on 05/14/21.
-There was no documentation Resident #1 had complained of mouth pain.
-She thought it possible the other provider had not been informed by facility staff that Resident #1 complained of mouth pain because communication between facility staff and providers was "not good".
-She did not know why there was a delay by the facility in notifying her office of Resident #1's mouth pain.

Attempted telephone interview with Resident #1 on 07/09/21 at 11:41am was unsuccessful.

4. Review of Resident #18's current FL2 dated 05/18/21 revealed diagnoses included cerebrovascular accident (stroke), hypertension, and dementia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 100	D 273		

a. Review of Resident #18's signed physician orders dated 06/08/21 revealed there was an order to discontinue eliquis (a medication used to treat and prevent blood clots) and start pradaxa 150mg, one capsule twice daily (a medication used to treat and prevent blood clots).

Review of Resident #18's June 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for eliquis 2.5mg, one tablet twice daily at 9:00am and 9:00pm.
-The Eliquis entry was documented as discontinued on 06/09/21.
-There was an entry dated 06/09/21 for pradaxa 150mg, one capsule twice daily at 8:00am and 8:00pm.
-There was no documentation pradaxa was administered from 06/10/21 to 06/30/21 at 8:00am and 8:00pm except on 06/10/21 when it was documented as administered one time at 8:00am.

Review of Resident #18's June 2021 medication notes revealed:
-There were 41 documented instances Resident #18's pradaxa was documented as not available to administer.
-Documented reasons the pradaxa was not available included 'awaiting pharmacy', 'on order', 'not available pending deliver from pharmacy', not available', 'medication not covered by insurance', 'insurance rejecting medication'.
-There was no documentation Resident #18's PCP was notified.

Review of Resident #18's July 2021 eMAR revealed:
-There was an entry for pradaxa 150mg, one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 101	D 273		

capsule twice daily at 8:00am and 8:00pm.
-There was no documentation pradaxa was administered from 07/01/21 to 07/08/21.

Review of Resident #18's July 2021 medication notes revealed:
-Documented reasons the pradaxa was not available include 'on order', 'medication not covered by insurance', 'not available, pending delivery from insurance' and 'not available, will contact pharmacy'.
-There was one instance, on 07/08/21. there was documentation the physician would be contacted.
-There was no follow-up documentation the physician was contacted.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed:
-The pharmacy received the order to discontinue Resident #18's eliquis and start pradaxa 150mg one capsule twice daily on 06/09/21.
-The pharmacy was not able to send the pradaxa because of insurance reasons.
-It was the facility's responsibility to notify the PCP of the insurance issues and ask if any medication changes were needed.
-Both pradaxa and eliquis are blood thinning medications and decrease the risk of a stroke.
-Resident #18 was at a greater risk of stroke because she was not receiving either medication.

Interview with Resident #18's Primary Care Provider (PCP) on 07/12/21 at 10:53am revealed:
-She was not notified Resident #18 was not receiving her blood thinning medication.
-Resident #18 had atrial fibrillation, an irregular heart rhythm that increased the risk of a blood clot that could cause a stroke or death.
-Without receiving blood thinning medication,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 102	D 273		

Resident #18's risk of a blood clot was further increased.
-She expected to be notified immediately if a resident's blood thinning medication was not available for administration.

Interview with a medication aide (MA) on 07/08/21 at 8:35am revealed:
-The Resident Care Director (RCD) told her Resident #18's pradaxa was being rejected by the insurance company.
-She was unsure when the RCD informed her.
-She told the RCD daily Resident #18's pradaxa was not on the medication cart.
-The MAs were responsible for contacting the pharmacy for routine medication refills, but the RCD was responsible for contacting the pharmacy for any other medication issues.
-The RCD was responsible for notifying the PCP if medications were denied by the insurance company.

Interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm revealed:
-She was responsible for following up on new medication orders.
-Resident #18's pradaxa had not been sent to the facility because of an insurance issue.
-She faxed the insurance paperwork to the PCP when she received it.
-She tried to follow up on medication issues but often forgot.
-There was no system in place for following up on medication issues, so she relied on her memory.
-She emailed Resident #18's PCP the previous week regarding the pradaxa but had not received a return email yet.

Attempted interview on 07/09/21 at 1:05pm revealed Resident #18 was not interviewable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 103 5. Review of Resident #13's current FL2 dated 03/20/19 revealed: -Diagnoses included cerebral palsy and hypertension. -Resident #13 was continent of bowel and bladder. Review of Resident #13's Care Plan dated 06/30/21 revealed: -Resident #13 was non-ambulatory and used a wheelchair. -Resident #13 had chronic constipation. Review of Resident #13's physician's orders signed 06/04/21 revealed an order for polyethylene glycol 3350 17gm (used to treat occasional constipation or irregular bowel movements) dissolved in an 8oz beverage of choice every day. Interview with Resident #13 on 07/07/21 at 10:15am revealed: -She suffered from chronic constipation and she drank prune juice to help with this daily. -She also had an order for daily polyethylene glycol to take daily to help relieve her constipation. -She refused the polyethylene glycol often because she felt like she did not need it. -Sometimes when she took the polyethylene glycol, she felt like it was too much for her when she had also drank prune juice and she would have to stay in her room during meal time because she was afraid to be too far from her bathroom. -She mentioned several times to the medication aide (MA) that she would like for the order for polyethylene glycol to be changed to possibly every other day or as needed but this had not happened.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 104 -Last week her private caregiver had also recently spoken with the MA about reducing the frequency of the order but nothing had happened. Interview with the MA on 07/07/21 at 11:40am revealed: -Last week Resident #13's private caregiver had mentioned to her that she thought Resident #13 was getting her polyethylene glycol too often and it was causing her to have to use the bathroom too frequently. -The caregiver asked if the polyethylene glycol order could be changed to every other day. -She thought she had made a note in Resident #13's progress notes about this but she could not recall, for sure. -The Resident Care Director (RCD) or Health and Wellness Director (HWD) or another nurse in the clinic should be reviewing any notes documented for each resident to see if follow-up was required on any issues. -She did not reach out to Resident #13's physician to ask about the request to change the order for polyethylene glycol from daily to every other day. Interview with Resident #13's private caregiver on 07/12/21 at 4:35pm revealed: -Resident #13 had always suffered from chronic constipation and to help manage this she drank a glass of prune juice daily. -Resident #13 also had an order for polyethylene glycol to be administered daily. -Resident #13 often complained that she thought the daily order for polyethylene glycol was too much to be taking when she was drinking prune juice daily. -Resident #13 would often skip meals and not go to the dining room for meals because she was afraid she may need to use the bathroom before	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 273	Continued From page 105	D 273		

she could get back to her room.
-Resident #13 frequently refused the polyethylene glycol when her stomach was upset or she was not having an episode of constipation.
-She spoke with a MA last week about reducing Resident #13's order for polyethylene glycol to less frequently than daily.
-Resident #13's order for polyethylene glycol had not changed since she spoke with the MA last week.

Telephone interview with Resident #13's Primary Care Physician (PCP) on 07/13/21 at 9:20am revealed:
-The facility had not communicated with him regarding her request to change the order for polyethylene glycol.
-If Resident #13 was drinking prune juice daily to help with her chronic constipation and was having regular daily bowel movements, it would be reasonable to reduce the frequency of the polyethylene glycol order to less than every day.
-His expectation was that the facility would communicate with him anytime there was a concern or question about Resident #13's medication regimen.

Interview with the HWD on 0707/21 at 12:10pm revealed:
-She was not aware of Resident #13's request to have the order for polyethylene glycol reduced to less than daily or her refusals of the medication.
-When residents expressed concerns with their medication orders, the MA should document the concern in the resident's nursing notes and communicate with a facility nurse about the concern.
-MAs were also able to share any resident's concerns about their medications with the PCP by fax.

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 273	Continued From page 106 -MAs and PCAs should be using the communication log daily to document any concerns or issues related to medications and a facility nurse should be reviewing this documentation daily to assure follow-up is completed as needed on any issues identified. -When a "progress note" was documented for a resident, it should "pop up" when the nurses are reviewing documentation for 3 days for review to help assure follow-up was completed. -MAs were also supposed to flag any new orders or communication with physician's in the resident's chart and place the chart in the "hot box" area of the facility clinic so that a nurse can assure follow-up is completed. _____ The facility failed to notify the primary care physician (PCP) to meet the health care needs for a resident who was presenting with respiratory symptoms, lower extremity edema, falls which resulted in a facial and shoulder abrasion, and traumatic avulsion of a toenail and subsequently admitted to the hospital for acute cystitis and IV antibiotics, a speech evaluation for swallowing issues, dressing changes to the toenail and evaluation of arterial insufficiency (Resident #2); a resident who did not receive a cardiology evaluation for management of a pacemaker and anticoagulation therapy which was ordered 01/27/21 and 05/18/21 (Resident #5); and a resident who was ordered and went without a medication to treat and prevent blood clots for a month (Resident #18). This failure resulted in serious neglect and constitutes a type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on July 8, 2021 for this violation.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 107 THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 12, 2021.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to implement orders for 4 of 7 residents, related to the application and removal of thromboembolic deterrent hose (Resident #3 and #9), orders for weekly blood pressure checks (Resident #7) and a diet change (#20). 1. Review of Resident #9's FL2 dated 04/07/21 revealed -Diagnoses included, pulmonary embolism, syncope and collapse, essential hypertension and anxiety disorder. -Resident #9 required personal care assistance with bathing, dressing. -There was an order for knee heighten stockings, on in the AM and off at hours of sleep (HS). Review of Resident #9's Resident Register	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 276	Continued From page 108 revealed an admission date of 03/31/21. Review of Resident #9's Care Plan dated 06/21/21 revealed: -She required supervision with toileting. -She required extensive assistance with bathing, dressing and grooming. Review of Resident #9's current Licensed Health Professional Services (LHPS) dated 05/18/21 revealed: -There was a task for TED hose. -There was documentation of Resident #9 was not wearing the TED hose and staff did not know where they were. Review of Resident #9's facility Resident General Notes revealed there were no entries related to TED hose. Observation of Resident #9 on 07/07/21 at 9:50am revealed: -She was lying in bed on her back. -There were no TED hose on Resident #9. Observation of Resident #9 on 07/07/21 at 12:00pm revealed: -She was lying in bed on her back. -There were no TED hose on Resident #9. Observation of Resident #9 on 07/07/21 at 2:00pm revealed: -She was lying in bed on her back. -There were no TED hose on Resident #9. Observation of Resident #9 on 07/07/21 at 4:00pm revealed: -She was lying in bed on her back. -There were no TED hose on Resident #9.	D 276		

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D 276	Continued From page 109 Observation of Resident #9 on 07/08/21 at 8:00am revealed: -She was in bed laying on her back. -There were no TED hose on Resident #9. Interview with a pharmacist with the facility's contracted pharmacy on 07/08/21 at 11:00am revealed: -There was a physician's order dated 04/12/21 for TED hose apply in the AM and remove at bedtime, need measurements. -The 04/12/21 physician's order was not dispensed on 04/12/21 because the facility did not respond to the faxed request for measurements. -The measurements were faxed to the pharmacy on 06/02/21 and 2 pair of TED hose were dispensed to the facility on the same day. -A second set of measurements were received from the facility on 06/15/21 with a new physician's order for TED hose apply in the AM and remove at bedtime, and 2 pair of TED hose were dispensed to the facility on the same day. -There was no discontinue order just a change of physician on 06/15/21. -There were no other requests for TED hose from the facility. -Four pair were dispensed to the facility for Resident #9 since the original 04/12/21 order. Review of Resident #9's May 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply TED hose in the morning and remove at bedtime. -There was no documentation TED hose were applied or removed on 05/01/21/ to 05/14/21 at 8:00am and 8:00pm. -There was an entry for TED hose documented as applied on 05/25/21 and 05/30/21 at 8:00am.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 276	Continued From page 110 -TED hose were not documented as applied or removed on 05/15/21 to 05/17/21 because "on order", 05/18/21 to 05/21/21 because "needs measurements", 05/22/21 to 05/23/21 because "awaiting a discontinue order", 05/24/21 because "need measurements" 05/26/21 to 05/29/21 and 05/31/21 "awaiting discontinue order". -The TED hose was not documented as applied for 29 out of 31 days. Review of Resident #9's June 2021 electronic eMAR revealed: -There was an entry to apply TED hose in the morning and remove at bedtime. -There was no documentation TED hose were applied or removed on 06/16/21, 06/17/21, 06/19/21, 06/20/21, 06/22/21, 06/23/21, 06/25/21 to 06/27/21, and 06/29/21 to 06/30/21 at 8:00am and 8:00pm. -There was an entry for TED hose documented as applied on 06/03/21 to 06/15/21, 06/24/21 and 06/28/21 at 8:00am. -TED hose were not documented as applied or removed on 06/01/21 to 06/02/21 because awaiting a "discontinue order", 06/18/21 because "refused", and 06/21/20 because"not applied". -The TED hose was not documented as applied for 4 out of 30 days. Review of Resident #9's July 2021 electronic eMAR revealed: -There was an entry to apply TED hose in the morning and remove at bedtime. -There was no documentation TED hose were applied or removed on 07/02/21 to 07/05/21. -There was an entry for TED hose documented as applied on 07/07/21. -TED hose were not documented as applied or removed on 07/01/21 because "on order" and 07/06/21 because "on order".	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 276	Continued From page 111 -The TED hose was not documented as applied for 6 out of 7 days. Interview with a personal care aide (PCA)/medication aide (MA) on 07/08/21 at 8:45am revealed: -Resident #8 was supposed to wear TED hose but they had not been available many times and at one point she thought they were discontinued. -The PCAs were to go find the TED hose in the laundry first if they were not in the residents room, then look on the medication cart for a new pair and if not there report it to the Resident Care Director (RCD), an Licensed Practical Nurse (LPN) or Health and Wellness Director (HWD), a Registered Nurse (RN) so they could order more from the pharmacy. Telephone interview with Resident #9's Power of Attorney (POA) on 07/08/21 at 7:20pm revealed: -Resident #9 was to wear the TED hose to help prevent blood clots from forming in her legs. -She was admitted to the hospital in April of 2021 for blood clots in her legs. -Resident #9 used to be ambulatory with assistance until this last hospitalization in April 2021. -After that hospitalization, Resident #9 had become bedridden. -Since Resident #9 was bedridden the TED hose were more important because she did not get her legs moving as much which could cause clots to form again, according to the physician. -She visited Resident #9 last week on Tuesday and Resident #9 was in bed so she did not see if the TED hose were on. -She did not recall seeing TED hose on Resident #9 since April 2021. -She expected the facility to put the TED hose on as ordered to prevent blood clots from forming.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 276	Continued From page 112 Telephone interview with the RCD on 07/12/21 at 9:13am revealed: -She was an LPN. -She started at the facility at the end of May 2021. -A MA asked her to discontinue Resident #9's TED hose because Resident #9 was not wearing them and Resident #9 did not get out of bed and Resident #9's feet were not swollen anymore. -She went to assess Resident #9 and found Resident #9 with 1+ pitting edema on the lower extremities. -There were no TED hose available so she got new measurements on Resident #9 and ordered new TED hose on 06/01/21. -On 06/15/21, she had to take more measurements because Resident #9's TED hose were missing again, and she ordered 2 more pair from the pharmacy. -On 06/15/21, she found Resident #9's TED hose in the bottom drawer of the medication cart. -The PCAs were responsible for applying the TED hose in the mornings and taking them off at night. -The MAs were responsible for checking behind the PCAs and documenting the application of the TED hose on the eMAR. -She did not see Resident #9 wearing TED hose. -The TED hose were to prevent blood clots in Resident #9 legs due to a history of blood clots and Resident #9 did not get out of bed. -She expected the PCAs to apply the TED hose every morning and if the TED hose were not in Resident #9's room, check laundry, then the medication cart, and then notify MA if not found. -The MA was responsible for notifying her if they were not found and she would order more from the pharmacy after she acquired the new measurements.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 276	Continued From page 113 Telephone interview with Resident #9 Primary Care Physician (PCP) on 07/12/21 at 11:41am revealed: -She first saw Resident #9 on 06/14/21 because she took Resident #9 over from another provider in her office. -Resident #9 had a history of blood clots. -She reviewed the current FL2 dated 04/07/21 and saw TED hose were ordered. -She wrote a new order for TED hose. -The facility nurse did not mention Resident #9 was not wearing the TED hose as ordered. -Resident #9 was at greater risk for blood clots because of her recent history of blood clots, being bedbound, decreased activity and not wearing the TED hose. -She expected the staff to apply the TED hose every morning and remove them at night as ordered to help prevent Resident #9 from getting blood clots. -A blood clot could cause death if one developed and went to her heart. Interview with the Executive Director (ED) on 07/09/21 at 12:05pm revealed: -The MAs were responsible for ensuring all physician orders were followed. -She did not know Resident #9 did not have TED hose. -When monthly medication cart audits were completed the MAs were to look for Resident #9's TED hose and reorder them if Resident #9 did not have them. -She depended on the clinical staff to oversee all of Resident #9's physician orders to ensure she had her TED hose. 2. Review of Resident #7's current FL2 dated 02/03/21 revealed:	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 276	Continued From page 114	D 276		

-Diagnoses included dementia and hypertension.
-There was an order to check blood pressure (BP) readings weekly.

Review of Resident #7's March 2021 through July 2021 electronic medication administration records (eMAR) revealed:
-There were no entries for BP checks weekly.
-There was no documentation Resident #7's BP was checked weekly.

Review of Resident #7's vital signs log report from 02/03/21 through 07/08/21 revealed there were no BP readings documented.

Interview with the medication aide (MA) on 07/08/21 at 9:15am revealed:
-She did not remember taking weekly BP readings for Resident #7.
-She only took BP readings if they were entered on the residents eMAR or there was an acute situation.
-There were no entries on the eMAR for weekly BP readings for Resident #7.

Interview with the facility's contracted pharmacy staff on 07/13/21 at 11:06am revealed:
-They received Resident #7's FL2 dated 02/03/21.
-The pharmacy staff entered orders and treatments received from physicians onto the eMAR.
-The pharmacy staff had missed the weekly BP orders on the FL2 sent from the facility upon admission, and it was never entered on the eMAR.
-The facility staff could also enter orders and treatments on the eMAR.
-When the pharmacy staff entered an order or treatment, the facility staff had to approve the

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 276	Continued From page 115 entry was correct before the order or treatment became active and could be administered by the MAs. Interview with the Health and Wellness Director (HWD) and the Resident Care Director (RCD) on 07/12/21 at 3:05pm revealed: -She and the RCD provided oversight to medication orders and treatments for the residents. -The FL2 was sent to the pharmacy to enter the orders/treatments onto the eMAR. -She or HWD reviewed the order once it was entered on the eMAR and verified its accuracy. -Once verified, the MAs could administer the medication or perform the treatment. -They did not know Resident #7 had a weekly BP order on her admitting FL2 that was never entered on the eMAR. Interview with the Resident #7's PCP on 07/13/21 at 12:51pm revealed: -Resident #7 transferred to her care after her admission in February of 2021. -She did not write the orders on the admitting FL2. -She did not know why the previous physician ordered weekly BPs for Resident #7. -Since blood pressure readings were not taken, she did not know Resident #7's baseline BP. -She expected the facility staff to implement orders from the prescribing physicians. Interview with the Executive Director (ED) on 07/12/21 at 2:50pm revealed -FL2's received upon admission should be sent to the PCP for verification. -Once verified, the FL2 should be sent to the pharmacy to enter the medications and treatments into the eMAR.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 276	Continued From page 116	D 276		

-The RCD or HWN then verified the correct entry of the order, comparing the original orders with the entries on the eMAR.
-The order then becomes active and the MAs can view it on their IPad and administer the medications/treatment to the resident.
-She did not know who was responsible at the facility for verifying residents orders on an FL2 or what the process was at that time.
-She did not know Resident #7 had a weekly blood pressure order on her FL2 dated 02/03/21 that was never implemented.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

3. Review of Resident #3's current FL2 with no date revealed:
-Diagnoses included Alzheimer's disease, nocturia (frequent urination at night)related to benign prostate hyperplasia, diabetes, and bilateral lower extremity edema.
-Resident #3 required personal care assistance with bathing, dressing, grooming, and toileting.

Review of Resident #3's signed physician's orders dated 03/26/21 revealed an order to apply thromboembolic deterrent hose (TED hose) in the morning and remove at bedtime.

Review of Resident #3's Care Plan dated 09/03/20 revealed:
-Resident #3 required extensive assistance with toileting.
-Resident #3 required limited assistance with bathing, dressing, and grooming.

Observation of Resident #3 on 07/08/21 between 9:15am and 9:48am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 117 -Resident #3 was not wearing TED hose. -Resident #3 was wearing white athletic socks and tennis shoes. -Resident #3's right lower extremity from the knee to ankle was swollen larger than his left leg. Observation of Resident #3 on 07/09/21 at 4:40pm revealed: -Resident #3 was not wearing TED hose. -Resident #3 was wearing white athletic socks and tennis shoes. -Resident #3's right lower extremity from the knee to ankle was swollen larger than his left leg. -Resident #3's right tennis shoe was untied. Interview with Resident #3 on 07/09/21 at 8:30am revealed he did not want to tie his tennis shoe because it was too tight and hurt when it was tied. Review of Resident #3's May 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply TED hose in the morning and remove at bedtime. -The TED hose were not scheduled to applied at a specific time in the morning. -The TED hose were scheduled to be removed from 05/01/21 to 05/31/21 at 9pm. -There was no documentation TED hose had been applied the entire month in the morning. -The TED hose were documented as removed the entire month at 9pm. Review of Resident #3's June 2021 electronic eMAR revealed: -There was an entry to apply TED hose in the morning and remove at bedtime. -The TED hose were not scheduled to applied at a specific time in the morning. -The TED hose were scheduled to be removed	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 276	Continued From page 118	D 276		

from 06/01/21 to 06/30/21 at 9pm.
-There was no documentation TED hose had been applied the entire month in the morning.
-The TED hose were documented as removed the entire month at 9pm.

Review of Resident #3's July 2021 electronic eMAR revealed:
-There was an entry to apply TED hose in the morning and remove at bedtime.
-The TED hose were not scheduled to applied at a specific time in the morning.
-The TED hose were scheduled to be removed from 07/01/21 to 07/08/21 at 9pm.
-There was no documentation TED hose had been applied the 07/04/21 to 07/08/21 in the morning.
-The TED hose were documented as removed 07/01/21 to 07/08/21 at 9pm.

Interview with a first shift medication aide (MA) on 07/08/21 at 10:00am revealed:
-She did not know Resident #3 had an order for TED hose.
-She did not find his TED hose on the medication cart or in his room.

Interview with the second shift MA on 3:10pm revealed:
-The PCAs were responsible for putting them on and taking them off.
-She documented the TED hose as removed on the eMAR at 9:00pm because Resident #3 did not have TED hose on when she saw him.
-She never saw TED hose for Resident #3.

Interview with Resident #3's Primary Care Provider (PCP) on 07/08/21 at 3:45pm revealed:
-Resident #3 had a physician order for TED hose.
-Resident #3 needed to wear TED hose to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 276	Continued From page 119	D 276		

decrease swelling and improve circulation in his lower extremities.

Interview with the Resident Care Director on 07/09/21 at 10:30am revealed:
-The staff who verified Resident #3's TED hose scheduled them for 9:00pm only.
-When Resident #3's order for his TED hose was entered into the eMAR by the pharmacy it was then verified by staff and ensure both times to apply and remove the TED hose were added to the eMAR.
-When the order for Resident #3's order was verified, the person verifying the order was supposed to enter the times for applying and removing his TED hose.
-The MAs were expected to check after the PCAs if the PCAs were removing Resident #3's TED hose to make sure it was done.
-The first shift MA would not see the order for Resident #3's TED hose if it was not scheduled.

Interview with the Executive Director (ED) on 07/09/21 at 12:05pm revealed:
-The MAs were responsible for ensuring all physician orders were followed.
-She did not know Resident #3 did not have TED hose.
-When monthly medication cart audits were completed the MAs were to look for Resident #3's TED hose and reorder them if Resident #3 did not have them.
-She depended on the clinical staff to oversee all of Resident #3's physician orders to ensure he had his TED hose.
4. Review of Resident #20 current FL2 dated 10/15/20 revealed:
-Diagnoses included anxiety, dementia and high blood pressure.
-There was an order for a mechanical soft diet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 120 Review of Physician's Diet Order form for Resident #20 dated 01/05/21 revealed an order for a regular diet. Review of Memory Care therapeutic diet list in the kitchen on 07/13/21 revealed: -Resident #20 was listed under mechanical soft diet. -The list was typed and did not have any handwriting on it. -The list did not have a date on it. Review of the week at a glance menu revealed the lunch meal on 07/13/21 for the regular diet was a green leaf salad, a cut of roast beef, cooked cabbage and cubed oven roasted potatoes. Observation of the lunch time meal service on 07/13/21 at 11:30am revealed Resident #20 received roast beef that was cut into small pieces, cooked cabbage and cubed oven roasted potatoes. Interview with the Dietary Manager (DM) on 07/13/21 at 10:32am revealed: -He made the therapeutic diet list on his computer and did not put a date on it since he would update the list whenever diet changes were made. -When he was too busy to update the printed therapeutic diet list dietary staff would write in the updated diet orders. -The list that was observed in the kitchen on 07/13/21 was made on 07/12/21. -When a resident's diet changed the Health and Wellness Director (HWD) gave him an updated diet change sheet or emailed him the updated order.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 276	Continued From page 121 -He would honor the diet change without an official physician's order but always requested that the nurse send a diet change sheet with a physician's signature to him. Interview with the HWD on 07/13/21 at 3:13pm revealed: -An order to change a resident's diet was usually faxed from the primary care provider (PCP) on a signed physician's diet order form. -She hand delivered the form to the DM or placed in his staff mailbox. -When she was not in the building to receive the fax, other staff members would place the form in the DM's staff mailbox. -She was not working at the facility when Resident #20's diet order was changed from mechanical soft to regular. -She did not know why the kitchen was still serving Resident #20 a mechanical soft diet when her current diet order was for a regular diet. -She had not performed an audit of the diet orders in the resident's record compared to the therapeutic diet order list in the kitchen. -For best practice, she would expect the DM to meet with the leadership team to compare the kitchen's therapeutic diet list with the orders that the clinical staff had; however, this was not a current pratice at the facility. Interview with the Executive Director (ED) on 07/13/21 at 2:10pm revealed: -New diet orders were faxed to the HWD and put in her staff mailbox when she was not in building. -She expected the HWD to communicate the new diet order to the DM. -The Special Care Manager (SCM) or the HWD in training were responsible for communicating the diet order changes when the HWD was not present.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 276	Continued From page 122 The facility failed to ensure physician orders were implemented for residents with orders for the application and removal of thromboembolic deterrent hose (Resident #3 and #9) increasing the risk for lower extremity swelling, decreased circulation and blood clots. The facility's failure was detrimental to the health of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/08/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 27, 2021.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure residents were treated with respect, consideration, and dignity related to a resident who was continent was made to wear incontinent briefs and go to bed early because staff refused to assist with her personal care needs (#13); a resident who resided in the Assisted Living (AL) with an order to be admitted to the Special Care Unit (SCU)	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 338	Continued From page 123	D 338		

and remained on the AL with behaviors (#6); a resident on the AL was taken to the SCU during the day and returned to the AL during the night which worsened behaviors (#5, #6); staff refusing to assist a resident who required assistance with transfers and/or causing pain with transfers resulted in the resident rarely getting out of bed for three months (#9); a delay in call bell response with residents who required assistance (#12); and residents in the AL having to contend with dementia behaviors that were not resolved by staff; two resident with room changes without consent to move (#1, #6).

The finding are:

1. Review of Resident #13's FL2 dated 03/20/19 revealed:
-Diagnoses included cerebral palsy and hypertension.
-Resident #13 was semi-ambulatory with assistance.
-Resident #13 was continent of bowel and bladder.

Review of Resident #13's Care Plan dated 06/30/21 revealed:
-Resident #13 was non-ambulatory and used a wheelchair.
-Resident #13 had daily instances of bowel and bladder incontinence, had a commode chair in her bathroom, and had chronic constipation.
-Resident #13 had slow start and stop regarding speech due to her diagnosis of cerebral palsy.
-Resident #13 required extensive assistance with toileting, bathing, and transferring; and limited assistance with ambulation/locomotion, dressing, and grooming/personal hygiene.
-There was no documentation of Resident #13 wearing incontinence briefs at night.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 338	Continued From page 124 Interview with Resident #13 on 07/07/21 at 10:15am revealed: -She was told by a staff member that she must go to bed by 7:30pm each night because she was too busy to assist her after that time and that she would have to wear an incontinence brief at night. -She would have preferred she be allowed to stay up until at least 8:30pm so that she could use the bathroom later before going to bed but this was not allowed. -She was continent of bowel and bladder. -She did not have incontinence briefs of her own to wear because she was not incontinent but the staff member would bring a "pull-up" style incontinence brief or occasionally a feminine napkin instead. -She did not recall ever having an accident since she had lived at the facility. -She had worked hard her entire life to overcome her disability, learning to be as independent as possible from an early age. -Since she had little control over this situation, she managed by "cutting off all fluids" at 4:00pm daily, before she had dinner, so that she would not have to urinate between 7:30pm and 6:30am. She would drink two 23-ounce bottles of water earlier in the day, along with juice to help with her chronic constipation. -She was not incontinent of bowel or bladder and it was humiliating to her to be forced to wear a incontinence brief at night because staff refused to get her up after she was already in bed. -If they would put her to bed later, she would at least be able to urinate later before being put to bed but this was not an option, as a staff member had told her that "all residents on this hall who required assistance must be in bed by 7:30pm." -She was aware of other residents who had been told they had to wear an incontinence brief	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 338	Continued From page 125	D 338		

overnight even though they were still continent. Some of them were not able to hold their urine the whole night because they were put to bed so early and had decided to "just go" in the brief when they were not able to get assistance to the restroom at night.
-She felt like she had no control over decisions about her personal care and was "at the mercy" of staff to provide assistance as they desired.
-It was humiliating to have to wear a brief but she had been compliant with the staff members directive to do so.

Interview with Resident #13's private caregiver on 07/09/21 at 11:25am revealed:
-She came to the facility Monday - Saturday 2:00pm to 6:00pm to visit Resident #13 and provide companionship and assist her with her needs.
-Resident #13 told her that she was required to wear an incontinence brief at night because staff refused to provide assistance with toileting her after she was in bed and said "once they lay her down, they are not getting her back up" and that Resident #13 should not be wearing briefs because she was continent.
-Resident #13 did not want to go to bed until later though so she could use the bathroom before being put to bed but staff did not give her a choice in this.
-She did not notify anyone.

Interview with the Resident Care Director (RCD) 07/12/21 at 2:00pm revealed:
-She was not aware of Resident #13 wearing an incontinence brief at nighttime and thought Resident #13 was continent.
-Resident #13 was alert and oriented and was able to tell staff when she needed to use the restroom.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 338	Continued From page 126 -The expectation was that staff would provide assistance with toileting to Resident #13 or any other resident who was continent, as needed. Interview with the Health and Wellness Director (HWD) on 07/09/21 at 2:40pm revealed: -She was not aware of Resident #13 being forced to wear an incontinence brief at night. -This was unacceptable and the company's expectation was that residents who were continent and could express when they needed to use the restroom would be provided this assistance as needed. Interview with Executive Director on 07/09/21 at 4:45pm revealed: -She had no idea Resident #13 was wearing an incontinent brief at night. -Resident #13 was continent and should have been receiving assistance with toileting as needed at any time of day or night. 2. a. Review of Resident #5's current FL2 dated 10/06/20 revealed: -Diagnoses included dementia. -The recommended level of care was domiciliary. Review of Resident #5's Resident Register revealed Resident #5 was admitted to the facility on 10/23/20. Review of Resident #5's faxed Provider Visit/Order form revealed: -Staff concerns: Resident #5 was found across the street, claiming that she lived across the street 06/25/21. -The provider's response was since the facility did not use wander guard please reach out to Resident #5's responsible party (RP) to discuss possible transition to the special care unit (SCU)	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 127 on 06/29/21. Review of Resident #5's progress notes dated 07/01/21 revealed Resident #5 continued to attempt to leave the facility. Review of Resident #5's record revealed there was no order for Resident #5 to begin spending some time during the day in the SCU. Observation in the SCU on 07/09/21 and 07/12/21 between 8:00am and 2:00pm Resident #5 was observed being brought into the SCU and sat a dining room table in the secondary dining room. Interview with Resident #5 on 07/09/21 at 9:30am revealed: -She did not know why she could not go back "home" upstairs back to her room in the assisted living (AL). -She did not like being away from her bed and living area. -The staff brought her to the SCU before, but she did not like it. Interview with Resident #5's family member on 07/12/21 at 2:05pm revealed: -She was told Resident #5 was found across the 5-lane road in front of the facility twice because she thought she was going to church or the bank. -Staff told her Resident #5 was part of a day program where she visited the SCU during the day when the front doors to the facility were unlocked. -Staff told her in the evening when the front doors of the facility were locked Resident #5 could return to her room on the assisted living (AL). Interview with the SCU medication aide (MA) on	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 128 07/09/21 at 10:00am revealed: -Resident #5 was placed on the SCU just during time at the direction of the Health and Wellness Nurse (HWN) after Resident #5 eloped from the facility and found on the other side of the 5-lane road in front of the facility twice. -Resident #5 did not come to the SCU every day. Interview with the Activities Director on 07/12/21 at 11:15am revealed: -She was told to include Resident #5 in the activities provided in the AL during the time Resident #5 was visiting the SCU. -Resident #5 was part of a day program in the SCU during first shift almost every day. -She went to the SCU and brought Resident #5 to the activities she conducted with the other residents in the AL. Interview with Resident #5's Primary Care Provider (PCP) on 07/13/21 at 12:36pm revealed: -She did not know Resident #5 was participating in a day program that required Resident #5 to visit the SCU during the day. -She had not changed Resident #5's level of care. -She did not write an order for Resident #5 to visit the SCU daily or every other day. Interview with the Executive Director on 07/12/21 at 4:45pm revealed: -She knew Resident #5 was going to the SCU for a day program. -Resident #5 had attempted to elope from the facility was found across the main road in front of the facility twice. -The day program which involved Resident #5 being placed in the SCU was to allow Resident #5 to transition slowly and prevent Resident #5 from experiencing any agitation with a permanent move to the SCU.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 129	D 338		

-Resident #5 was to move into the SCU permanently after a few weeks of transiting from the AL to the SCU.

b. Review of Resident #6's FL2 dated 05/21/21 revealed:
-Diagnoses included diabetes mellitus type 2, hypertension, dementia, vitamin deficiency, dyslipidemia, and arthritis.
-Resident #6 required domiciliary level of care.
-Resident #6 was ambulatory and not documented to have wandering behaviors.

Review of Resident #6's Care Plan dated 02/21/21 revealed
-Resident #6 had wandering behaviors, exhibited socially disruptive behavior, resisted care, and was verbally abusive.
-Resident #6 was ambulatory with aide or assistive devices.
-Resident #6 was "always disoriented" and had "significant loss of memory" and "must be directed."
-Resident #6 required limited assistance, needing "prompting and reminders with toileting, bathing, dressing, and grooming. She required limited assistance with ambulation with a cane.
-Resident #6 required no assistance with eating or transferring.

Review of Resident #6's additional corporate Care Plan dated 02/22/21 revealed:
-Resident #6 was difficult to understand, required time to communicate or frequently needed team members to interpret speech or resident is unable to speak and required other methods to communicate. A comment documented that Resident #6 was "disoriented most of the time, difficult to communicate needs."
-Resident #6 was required cueing to participate in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 130	D 338		

social activities, meals, and/or redirection or may have behaviors that are difficult to redirect. A comment documented that she was disoriented.
-Resident #6 had made one or more attempts to leave community. No comments were documented in this section.

Review of Resident #6's Physician Visit Form dated 04/14/21 revealed:
-Resident #6 had a current diagnosis of worsening memory.
-The reason for visit was documented as confusion, agitation, urinary and fecal incontinence, worsening Alzheimer's Disease with behavior problems.
-There was an order for Resident #6 to upgrade to Special Care Unit (SCU) and to follow-up with neurologist.

Review of physician's office visit documentation dated 04/14/21 revealed:
-Resident #6 should be in the SCU as per the director.
-The physician documented she "should be upgraded to SCU written order provided and they should get the social worker at the facility on board to discuss further plan of action with her family member."

Based on observation, interviews and record reviews, it was determined Resident #6 was not interviewable.

Interview with the Executive Director (ED) on 07/12/21 at 4:45pm revealed:
-She initiated the one on one supervision for Resident #'6 at the recommendation of the Health and Wellness Director (HWD) in May 2021 because of Resident #6's increased wandering and exit seeking behaviors in the Assisted Living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 131 (AL). Observation of Resident #6 on 07/08/21 at 8:35am revealed she was walking throughout the assisted living portion of the facility without one-on-one supervision. Observation of Resident #6 on 07/08/21 at 2:00pm revealed she was visiting the Special Care Unit (SCU), sitting in the common area watching television with other residents. Observation of Resident #6 on 07/09/21 at 4:35pm revealed she was in the AL portion of the facility, at the top of the stairs on the 3rd floor foyer, yelling and screaming at staff. Interview with a personal care aide (PCA) on 07/09/21 at 4:40pm revealed: -Resident #6 often became upset and combative and would sometimes yell at staff. -Resident #6 had been downstairs in the special care unit for the day, but it was time for her to return the assisted living side of the facility and to have her blood pressure checked, which upset her and caused the outburst. -Resident #6 often spent her days in the SCU and then her evenings and nights in the AL portion of the facility. -The change of going to the SCU and the back to AL was difficult for Resident #6. Observation of Resident #6 on 07/12/21 between 8:30am and 9:10am revealed: -Resident #6 was wandering around the second floor around common areas and the concierge desk without supervision. -At 9:06am, a staff member approached and was able to take Resident #6 by the hand and lead her down the hallway away from the main entrance of	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 132 the AL. Observation of Resident #6 on 07/13/21 at 8:45am revealed: -Resident #6 was observed going into the SCU with a PCA from the 3rd floor. -She was very agitated and was yelling and attempting to hit staff. -Resident #6's shirt sleeve was torn on the inside of her arm. Observation of Resident #6 on 07/13/21 at 9:05am revealed Resident #6 had returned to the assisted living side of the facility and told the aide that was with her "I'm not going anywhere you are going." Interview with PCA on 07/13/21 at 9:05am revealed: -She was told by the third-floor medication aide (MA) to take Resident #6 to the special care unit so she could have more supervision because the main entrance to the facility could not be locked. -Every time, as soon as she got Resident #6 down to the SCU and she saw the locked doors to the SCU, she became very combative and upset. Review of Resident #6's Progress Notes revealed: -On 05/13/21, staff attempted to discuss Resident #6's quality of life, level of cognition, and how she would benefit from the SCU placement with the resident's responsible party. -On 06/12/21 at 2:13pm, Resident #6 was observed wandering the second floor. "Staff states she tried to go out the front door." Resident #6 was very confused and agitated and staff reported her being combative during care, noting she would yell and become verbally abusive	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 133 toward staff. Review of Resident #6's Progress Notes revealed: -On 04/04/21 at 4:20pm, Resident #6 was agitated today. Staff tried to redirect her to go upstairs and sit in the TV area but she refused to go and wanted to remain downstairs near the concierge desk. -Resident #6 cursed at staff and said she "would kill them." -Staff allowed her to calm down and eventually got her to go upstairs. Staff would "continue to monitor" the resident. Review of the facility' communication log for the AL revealed: -On 06/03/21 6:00am - 2:00pm Resident #6 was throwing different items at staff towards other residents. -On 06/05/21 10:00pm - 6:00am, Resident #6 was "angry during dinner in the dining room. Yelling all over the place" and that she was very confused and angry. -On 06/12/21, (shift not specified), Resident #6 was "unhappy today and very angry." -On 06/12/21 6:00am-2:00pm, Resident #6 had increased confusion. -On 06/12/21 2:00-10:00pm, Resident #6 seemed confused and upset. -On 06/13/21 2:00-10:00pm, Resident #6 seemed confused and upset. -On 06/15/21 6:00am - 2:00pm, Resident #6 was confused and going from room to room. She refused care from staff and later the PCA and MA were able to provide personal care to her. Interview with a MA on 07/08/21 at 9:15am revealed: -Resident #6 was often confused and combative.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 134 -When Resident #6 decided she wanted to go out of the front door, she was always very determined to do so. -Resident #6 preferred sitting by the concierge desk. -Staff would try to watch and keep her busy but if they had to go into a resident's room or other area of the facility where she was not permitted, she would become very upset. -Staff would attempt to redirect her by giving her activities or tasks to do such as folding her laundry, which sometimes helped calm her down. -She asked the previous Resident Care Director (RCD) if one-on-one supervision could be added for Resident #6 and was told this would not be possible and that the family was not open to moving her the SCU. Interview with a second MA on 07/08/21 at 10:23am revealed: -Resident #6 was "constantly confused" and had been going to the special care unit sometimes during the day for increased supervision, which sometimes upset her. -Staff would try to get Resident #6 to go to the SCU on "busy days" when there were move-ins or move-outs, or other visitors coming and going, so that she would be less likely to "slip out" of the main entrance. -If Resident #6 was not able to go the SCU for some reason, staff would lock the main entrance to the facility when she was "really exit seeking." Interview with a third MA on 07/08/21 at 10:30am revealed: -Resident #6 was very confused and combative. -Sometimes Resident #6 would get really upset when staff had to leave her alone while she was on the AL side of the facility. -When she had to leave Resident #6	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 135	D 338		

unsupervised on the AL side of the facility, she would give her a snack and sit her on a couch in the common area, where she would usually stay until the staff member returned.

Interview with current Special Care Manager (SCM) on 07/02/21 at 12pm revealed:
-She had worked in the building for about two weeks and she thought that was about the time Resident #6 had started coming to the SCU daily for the "day program."
-She was not sure how it was determined that Resident #6 was appropriate for the day program.
-Resident #6 would come to the SCU daily, after breakfast and stay until the main doors to the facility were locked in the evening, at 7:00pm.

Interview with Health and Wellness Director (HWD) on 07/12/21 at 2:40pm revealed:
-She was not aware that there was an order for Resident #6 to be moved to SCU written on 04/14/21.
-She recalled that there were some conversations with the Resident #6's responsible party in the last week of May regarding moving her to the SCU and the RP was open to this recommendation.

Interview with Executive Director (ED) on 07/08/21 at 3:00pm revealed:
-A few weeks ago, Resident #6 began participating in the facility's "day program" in which residents from the AL portion of the facility, who had been identified as appropriate for SCU level of care, would go to the SCU for the day and return to the AL side of the facility for the evening and night.
-Staff had several care plan meetings with the family regarding her need for increased supervision and the benefits of moving to SCU

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 136	D 338		

but the family had not been receptive to the idea of her being moved.
-There was no discussion with Resident #6's family regarding discharge.
-The family had recently become more open to the idea of Resident #6 moving to SCU but wanted to first meet the family of the proposed roommate and she also needed a new, smaller bed, to fit in the shared, neither of which had yet occurred.
-Resident #6's physician had written an order written in April 2021 for her to be moved to the special care unit.
-Resident #6 was very confused and insecure and would often "latch on" to her or other staff members in AL, which they tried to allow her to do in order to keep her from becoming upset.
-Staff would try to engage her in activities to keep her from wandering within the AL portion of the facility and to keep her calm.

Telephone interview with Resident #6's RP on 07/13/21 at 10:49am revealed:
-She spoke to the ED about moving Resident #6 to the SCU and she wanted to be evolved with the move to SCU.
-She wanted to see the room and set up the room prior to Resident #6's move to the SCU in order for the room more like home.

3. Review of Resident #9's current FL2 dated 04/07/21 revealed
-Diagnoses included, pulmonary embolism, syncope and collapse, essential hypertension and anxiety disorder.
-Resident #9 required personal care assistance with bathing, dressing.

Review of Resident #9's Resident Register revealed an admission date of 03/31/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 137 Review of Resident #9's Care Plan dated 06/21/21 revealed: -She required supervision with toileting. -She required extensive assistance with bathing, dressing and grooming. Telephone interview with Resident #9's Power of Attorney (POA) on 07/08/21 at 7:20pm revealed: -Resident #9 was bedbound since her last fall in April 2021. -She had become afraid to get up because the staff rushed to get her up and it caused her a lot of pain. -Instead of getting up and be in pain or scared of falling she would rather stay in bed. -She felt that Resident #9 not getting up more and more caused a bigger decline in Resident #9's overall health. -She expected the staff to take their time and assist Resident #9 up and put Resident #9 back to bed in an appropriate amount of time. Interview with Resident #9 on 07/09/21 at 4:00pm revealed: -She had been bedbound since April 2021 after a fall. -It hurt her when the staff came and got her up because they did not take their time and go slowly. -The staff on her floor had to wait on other staff from another floor to assist them to get her up. -She was considered a 2 person assist, and no one could assist her on their own. -Because it was very painful and the staff did not take their time, she would rather stay in bed. -When she was transferred to her recliner in the morning and the staff member who had a bad back worked on second shift, she would not be put back to bed until 11:00pm when different staff	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 138	D 338		

came in to put her to bed.
-With the pain from rushing to get up and the staying up for extended periods of time because a staff member has a bad back, she would just rather stay in the bed.

Telephone interview with the Resident Care Director (RCD) on 07/12/21 at 9:13am revealed:
-Resident #9 stayed in bed more than usual.
-She did not know Resident #9 was not getting up because of staff not taking their time to get Resident #9 out of bed which caused her pain.
-She was not aware Resident #9 had to remain up until 11:00pm because second shift would not assist her back to bed.
-Resident #9 should be in her recliner during the day for no more than 2-3 hours at a time.
-She expected the staff take their time because Resident #9 had been in the bed a lot and the staff needed to give Resident #9 time to feel safe and slower movements cause less pain.

Telephone interview with Resident #9's Primary Care Physician (PCP) on 07/12/21 at 11:41am revealed:
-Resident #9 had a fall prior to coming to the facility and broke her foot.
-She was in a rehabilitation facility for a few weeks and received physical therapy.
-After coming to the facility she fell again in April 2021.
-She did not sustain any injuries but the fall caused Resident #9 to fear transfers.
-She became scared during transfers and would stiffen up and pull back resisting staff's efforts.
-She became bedbound because of the lack of movement and fear.
-She expected the staff to take their time with getting Resident #9 out of the bed or with any transfer to prevent fear and pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 139	D 338		

-She expected the staff to get Resident #9 up everyday but only for a few hours at a time and put in bed for the night earlier than 11:00pm.

Telephone interview with the Executive Director (ED) on 07/13/21 at 2:35pm revealed:
-Resident #9 could bear weight and required 2 person assist with transfers.
-She was aware Resident #9 was scared with transfers so she showed the staff how to "be easy" and slow with transfers.
-She did not know Resident #9 would be left in the recliner until 11:00pm at night.
-She expected the staff to get Resident #9 up to her recliner no more than two hours at a time and put Resident #9 to bed well before 11:00pm and take their time transferring Resident #9 to decrease fear and pain.

4. Review of Resident #7's current FL2 dated 02/03/21 revealed:
-Diagnoses included dementia, mood disorder, and dysuria (pain with urination).
-Resident #7 required personal care assistance with bathing, dressing, grooming, and toileting.
-She was incontinent of bladder.

a. Observation of Resident #7 on 07/07/21 at 9:32am revealed:
-She was lying on her back in bed with her mouth open.
-Her tongue and the sides of her oral cavity had a thick layer of black residue and yellow crusting.
-The roof of her mouth had a thin yellow coating with patches of reddened skin.
-She had several teeth missing.
-There was some dried blood around the upper and lower gums.

Interview with the medication aide (MA) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 140 07/07/21 at 9:55am revealed: -Resident #7 had not been eating for the past few weeks. -The resident would grimace at times when staff attempted to feed her. -Hospice had provided nutritional supplements twice a day. -She had not offered them to the resident. -Recently when staff attempted to feed or give drink to the resident, she would not swallow. -She did not know if the resident had lost weight since admission. -The staff only weighed residents who had a physician's order. Interview with the personal care aide (PCA) on 07/07/21 at 10:15am revealed: -Resident #7 would cry out at times and push the staff away when attempting to feed her. -She told the staff her mouth hurt. -Sometimes she ate ice cream, but lately she would not eat anything. Interview with a second shift MA on 07/07/21 at 4:20pm revealed: -Resident #7's mouth had been in poor condition since she moved in to the facility in April, 2021. -When she ate, her gums would bleed and her teeth were soft and not firmly rooted to the gums. -She did not want to eat at times because of mouth pain. -She would grimace and push the staff's hand away from her mouth when they were assisting her at meals. -The staff were afraid the loose teeth would fall out during meals and Resident #7 would choke on one of them. -The Executive Director (ED) and Special Care Manager (SCM) were aware of the condition of the resident's oral cavity.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 141 Review of the SCU communication logs from 05/27/21 to 07/07/21 revealed: -There was an entry on 05/27/21. "The resident did not eat breakfast or lunch today and only drank very little water." -There were no other entries regarding Resident #7's mouth pain or difficulty eating. Telephone interview with the hospice Registered Nurse (RN) on 07/08/21 at 11:30am revealed: -Resident #7 was admitted as a hospice client on 05/25/20. -She visited Resident #7 twice a week and provided medication management for anxiety and agitation. -She documented dentition issues upon admission to hospice services. -Staff reported to her the resident was not eating due to mouth pain. -She changed her diet to puree and provided nutritional supplements. -She did not know if the resident had lost weight since she had no documented weights since admission to the facility. Interview with the Health and Wellness Director (HWD) on 07/12/21 at 3:15pm revealed : -She was aware Resident #7 had poor dentition.. -Staff had not reported the extent of the deterioration of her oral cavity and gums or she would have assessed the resident. -Resident #7 was admitted to the facility before she began her position, and she was told this issue had been ongoing and family was aware. -She did not know it had affected her ability to eat without pain. -She did not know if Resident #7 had lost any weight since the facility policy was to weigh residents only with a physician's order.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 142 Interview with the previous Special Care Manager (SCM) on 07/12/21 at 4:20pm revealed: -Resident #7 had poor oral hygiene and few teeth when she was admitted. -It was not reported to her that the resident had difficulty eating due to mouth pain -She would have reported the resident's pain to the hospice nurse and followed their directives. Interview with the Executive Director (ED) on 07/08/21 at 10:05am revealed: -She did not know Resident #7's dentition was causing her to avoid eating due to pain. -The staff had not reported this to her. -She had a meeting with the hospice RN regarding the resident's oral care, but there was no mention of her inability to eat. -She expected the MAs to report to the clinical staff all issues concerning resident care. b. Observation of Resident #7 on 07/07/21 at 4:30pm revealed: -There was a strong smell of urine in her room. -Resident #7 was lying in her bed and was doubled briefed with an incontinence pad underneath her bottom. Interview with a second MA on 07/07/21 at 4:30pm revealed: -She did not know Resident #7 was doubled briefed. -She had seen that occasionally at the facility, but did not know who was double briefing the residents. -She did not know the facility policy on double briefing residents who were incontinent, but she had been trained at another facility that it was not appropriate.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 143	D 338		

Interview with the hospice Registered Nurse (RN) on 07/07/21 at 11:45am revealed:
-Resident #7 was almost always in the bed or in the wheelchair in her room when she visited her twice a week.
-She informed the staff during her visits to the facility to reposition the resident every 2 hours to prevent skin breakdown.
-She also reminded staff to change her brief as needed as an intervention to prevent skin breakdown.
-The repositioning instructions were given to the MAs and PCAs who were working in the SCU when she visited Resident #7 twice a week.
-In addition she brought a box of supplies with body wash, mouthwash, briefs, bed pads and wash cloths.
-The entire box of supplies were missing at Resident #7's next scheduled visit.
-The hospice aide was informed by an employee of the facility that another resident in the SCU had diarrhea and Resident #7's supplies were used for them.

Interview with the previous Special Care Manager (SCM) on 07/12/21 at 4:20pm revealed:
-She had been the SCM until sometime near the end of June 2021.
-She had not been informed by the hospice RN that staff should be repositioning Resident #7 every 2 hours when in bed.
-She did not know some of the resident's supplies for personal care provided by hospice were missing.
-She did not know staff were double briefing incontinent residents.

Interview with the Health and Wellness Director (HWD) on 07/12/21 at 3:15pm revealed :
-Hospice was providing over site for the care of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 144	D 338		

Resident #7 since the end of May.
-She had not instructed the staff to reposition residents who were bed bound every 2 hours.
-She did not know incontinent residents were being double briefed.
-It was not the facility policy to double brief residents.
-Staff received training on personal care during orientation which included the policy on double briefing incontinent residents.
-She thought hospice gave the staff and the SCM instructions regarding the care of their residents.

Interview with the Executive Director (ED) on 07/08/21 at 10:05am revealed:
-It was not the policy of the facility to double brief residents.
-Staff were trained not to double brief residents during the first week of orientation, before providing care to the residents.
-It had not been reported to her staff were double briefing incontinent residents.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.

5. Review of Resident #12' FL2 dated 01/06/20 revealed:
-Diagnoses included acute and chronic respiratory failure, chronic kidney disease, Type 2 diabetes, and primary hypertension.
-The resident was semi-ambulatory with use of a wheelchair.

Interview with Resident #12 on 07/07/21 at 10:05am revealed:
-During the tour, Resident #12 reported the call bells were not answered in a timely fashion, especially on second and third shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 145 -Frequently at night when he needed assistance, staff did not respond to his call bell. Interviews with other residents on the second and third floor, during the initial tour on 07/07/21 from 9:10 through 10:30am, revealed complaints of staff not answering call bells in a timely fashion or not at all during second and third shift. Interview with the first shift MA on 07/08/21 at 10:20am revealed: -Residents on the second and third floor have pendants that activate a call bell on staff pagers. -Resident #12 informed her one morning last week that he had been sick during the night and was unable to get assistance from staff. -She worked first shift and at times the residents have complained they were unable to get staff assistance during the night. Review of the Zone Call Bell Activity Report for the period of 07/01/21 through 07/11/21 revealed: -On the second floor, the call bell response time greater than 10 minutes was 45 of 57 initiations. -Thirty of the 45 responses greater than 10 minutes were on second and third shift. -On the third floor, the call bell response time greater than 10 minutes was 74 of 100 initiations. -Fifty one of the 74 responses greater than 10 minutes were on the second and third shift. Interview with the Maintenance Director on 07/12/21 at 8:30am revealed: -The facility had been experiencing technical difficulties with the pager system. -In May 2021, the system was revamped and was working successfully. -However, the call bell log continued to show long waiting times between resident's pushing the pendant and staff response.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 146 -He had often seen pagers left on medication carts. -Staff would often not clear the pager after answering the call. -He had training sessions with new staff during orientation and as needed to demonstrate the usage of the pagers and call pendants. -However with agency personnel and staff turnover not all staff had been trained by him. -The Executive Director (ED)and nursing staff were aware of this issue. Interview with the ED on 07/12/21 at 4:45pm revealed: -The Maintenance Director pulled the call bell log weekly to review. -She was aware of the time discrepancies in staff answering the pagers to provide care for residents. -She thought there were hardware issues with the call bell system. -It was the responsibility of the Maintenance Director to review the call bell logs. -She did not review them herself. -When the Maintenance Director reported long gaps in response time during weekly management meetings, she would follow up with the residents. -Most of the time the residents state the staff responded to their call bell. -Some of the staff did not know how to turn off the resident's pagers and some of the staff would forget to turn them off. -She had requested the Maintenance Director conduct periodic refresher trainings for the staff. -She would expect a target 5-10 minute response time from the staff answering call bells. -She did not know residents complained their call bells were not answered at times during second and third shift..	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 338	Continued From page 147 6. Telephone interview with a resident's Power of Attorney (POA) on 07/08/21 at 4:30pm revealed: -On 05/10/21, after a conversation with her family member in the Special Care Unit (SCU), she emailed the Executive Director (ED) to inform the ED about a male resident entering her family members room. -Her family member asked the male resident to leave many times and after several attempts to get the male resident to leave, he did and had returned several times. -Her family member felt "unsafe" and felt she had no privacy. -On 05/24/21, after speaking with her family member she emailed the ED again with a new incident that happened over the weekend of 05/22/21 and 05/23/21. -This evolved a female resident who wandered into her family member's room, would not say anything, reorganized things, and would disrobe. -Her family member would call out for help and it would take a long time before someone would come and get the female resident out of her room. -This made her and her family member uncomfortable, feeling unsafe, and that there was no privacy. -She expected the ED to look into these episodes and call her back but she received an email with an apology and the ED would forward the previous emails to the previous Special Care Manager (SCM) to set up an appointment with her to discuss the concerns. -On 05/25/21, after no response from the previous SCM, she emailed the previous SCM dates and times she would be available to meet. -She did not receive a response from the ED or previous SCM related to a meeting to discuss her concerns regarding Resident #2's safety.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 148 Interview with a resident in the Assisted Living (AL) on 07/08/21 at 2:05pm revealed: -A resident frequently wandered into her room. Sometimes this would happen multiple times a day or night, but at minimum, it would occur several times a week. -She was told the resident lived directly above her room and was confused, not realizing she was on the wrong floor. -She would come in sometimes in the middle of the night and use her bathroom, waking the resident up. -Sometimes staff were not nearby and would not see her go into the resident's room, so she would have to yell at the resident until she left her room. -Sometimes when staff were nearby and would try to redirect the resident from her room, she would become combative and try to hit them. -The resident was not able to communicate well and would just talk "gibberish" back at her when she yelled at her to leave her room. -She was often startled by the resident and thought it was "creepy" when she woke up to the resident standing in her room looking at her sleeping. Interview with another resident in the AL on 07/09/21 at 10:12am revealed: -There was a resident in the facility that wanders into her room at night. -She was startled because she was not aware someone was in her room. -She was woken up once at 4:00am by the resident using her bathroom. -She had told staff about it, but they said there was nothing they could do. Interview with Resident Care Director in the AL on 07/12/21 at 2:00pm revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 149	D 338		

- She was not aware that there were confused residents residing on the AL side of the facility who wandered into other residents room during the day and night.
- She did not know how the facility could address wandering residents on the assisted living side of the facility because they "can't force residents to lock their doors."

Telephone interview with the previous Special Care Manager (SCM) on 07/13/21 at 10:25am revealed:
-The MCU did have residents with wandering behaviors and the staff attempted to redirect the residents.
-She expected the staff to redirect all residents who wander in other residents rooms.
-She did not recall an email related to a resident's POA safety in the SCU.
-She did not have a meeting with the previous SCU resident's POA regarding residents with wandering behaviors, entering the SCU residents room.

Telephone interview with the ED on 07/13/21 at 2:30pm revealed:
-She received an email from a resident's POA in the SCU concerning residents wandering in their family member's room and the safety concerns.
-She forwarded the email to the previous SCM to set up an appointment for the resident's POA to come to the facility and see the family member's room and discuss the issue further.
-She did not know the previous SCM did not respond to the resident's POA and a meeting did not take place.
-She expected the previous SCM to address the issue with the staff and contact the resident's POA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 338	Continued From page 150	D 338		

7. a. Review of Resident #6's FL2 dated 05/21/21 revealed:
-Diagnoses included diabetes mellitus type 2, hypertension, dementia, vitamin deficiency, dyslipidemia, and arthritis.
-Resident #6 required domiciliary level of care.

Review of Resident #6's original residency agreement signed 04/17/18 revealed she was assigned to a private room.

Telephone Interview with Resident #6's responsible party (RP) on 07/13/21 at 10:49am revealed:
-When Resident #6 first moved into the facility a few years ago, she moved into a private room.
-She was moved once with her permission to a companion room.
-Resident #6 was moved again from the companion room to a private room with all of her belongings without her consent.
-The Executive Director (ED) told her that she had been moved because they needed to clean her carpet and the move would be temporary.
-After being moved, the ED told her if she wanted Resident #6 to remain in the room she had been temporarily moved to, there would be an increase in her monthly fees.
-She told the ED that they would not pay any additional money because they had never given approval for her to be moved and that she should be moved back to her former companion room.
-Resident #6 was never moved back to her room.
-The ED who was there at the time was no longer working in the facility.
-She had visited about a month ago and observed Resident #6 to have more difficulty communicating, she was more irritated, and more confused.
-She felt the room change was not helpful to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 151 Resident #6's worsening confusion. Observation on 07/13/21 at 11:00am revealed Resident #6 was currently assigned to a private room. Interview with the Business Office Manager (BOM) on 07/12/21 at 11am revealed: -She recalled that Resident #6 had started out in a single room when she moved in and then moved to companion room for financial reasons. -She recalled her being moved from the companion room but she was not aware of the reason she was moved the second time. -She was not able to locate any documentation regarding room changes in Resident #6's business file. -She looked in their computer system to see if she could tell when she was moved to a private room but she could not identify when the room change occurred. -She thought there was an addendum that would be signed regarding room changes but she could not find any documentation and she was not certain because she was new to the BOM role. Interview with Maintenance Director (MD) on 07/12/21 at 12:40pm revealed: -He recalled moving Resident #6 out of a companion room, 4 of 5 months ago, due to the flooring needing to be replaced. -He was told this would be a permanent move and to move all of her belongings to a private room. Interview with the Health and Wellness Director (HWD) on 07/12/12 at 2:40pm revealed: -Usually room changes came as a request to the sales team from the resident's family members. -She did not think there was any additional	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 152	D 338		

paperwork or addendums that needed to be completed in order for a room change to occur.
-The RP should always give permission prior to a resident being moved and be made aware if it was intended to be a permanent move.
-There should be a conversation about the move prior to it occurring with all of the involved parties, including facility staff, the resident, and the RP.

Interview with the ED on 07/12/21 at 4:45pm revealed:
-Soon after becoming the ED, Resident #6's RP made her aware that Resident #6 had been moved without her consent or knowledge.
-Since she was not working at the facility at the time the move occurred, she could not speak to the specifics of the move.
-Generally, when a resident was moved from one room to another, the family would be notified ahead of time and would agree to the move before it occurred.
-When a resident was moved from a companion room to a private room, there were additional fees attached to their monthly bill.
-There was no documentation of the room change or additional fees applied to Resident #6's account.
-She was not aware of any additional paperwork that would be completed when room changes occurred.

b. Review of Resident #1's current FL2 dated 05/20/21 revealed:
-Diagnoses included hypertension, hypokalemia, dementia, vitamin D deficiency, anxiety, pain and atrial fibrillation.
-Resident #1 required domiciliary level of care.

Review of Resident #1's original residency agreement signed 03/29/19 revealed she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 153 assigned to a private room. Telephone interview with Resident #1's RP on 07/09/21 at 11:41am revealed: -Resident #1 had a fall and was sent out to the hospital. -While the resident was at the hospital, the Executive Director (ED) had her moved from one AL room to a different AL room without his knowledge or consent. -After she returned from the hospital the next day, he tried to call to check on her in her original room, and did not get an answer. -Concerned, he called the concierge's desk and was told that she had been moved. -When he spoke with the ED he was told that she had moved the resident because her carpet needed to be replaced and she would be moved back to her old room as soon as the work was completed. -Several days later, the ED called him again and suggested Resident #1 be moved to the second floor from the third floor, because she was not as ambulatory as she was when she was admitted, and it would be safer for her to be on the second floor. -He was open to this recommendation and told her that he would like to see the proposed room before he gave consent for her to be moved again, and that he planned to go to the building the following Saturday to see the room on the second floor before she was moved. -On Saturday, he arrived at the facility and learned from the concierge that Resident #1 had already been moved to the second floor 3 or 4 days earlier. -The concierge initially told him that he could go to her room for a visit but was then told he could not do so. -He was able to speak to Resident #1 on the	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 154	D 338		

telephone that day and said that she sounded very sad.
-She told him that her belongings were all still in boxes and that her television had never been set up.
-Resident #1 was non-ambulatory and did not participate in activities. Her main entertainment was watching television in her room and she had not been able to do this for several days.
-Resident #1 was very overwhelmed about her belongings not being unpacked and she could not complete this task without assistance.
-He was frustrated staff had not told him she was being moved or assisted her with unpacking her belongings after the last two moves that were made without his consent.

Interview with the Business Office Manager (BOM) on 07/12/21 at 11am revealed:
-She could not recall the specifics of why Resident #1 had a room change while she lived at the community.
-She was not able to locate any documentation regarding room changes in Resident #1's business file.
-She thought there was an addendum that would be signed regarding room changes but she could not find any documentation and she was not certain because she was new to her role.

Interview with the Health and Wellness Director (HWD) on 07/12/12 at 2:40pm revealed:
-Usually room changes came as a request to the sales team from the resident's family members.
-She did not think there was any additional paperwork or addendums that needed to be completed in order for a room change to occur.
-The RP should always give permission prior to a resident being moved and be made aware if it is intended to be a permanent move.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 155 -There should be a conversation about the move prior to it occurring with all involved parties, including facility staff, the resident, and the RP. Interview with the ED on 07/12/21 at 4:45pm revealed: -Soon after becoming the ED of the facility, Resident #1 had a fall and was sent out to the hospital for evaluation. She responded to Resident #1's incident to see if she was okay, and upon entering the room, observed the carpet was in very poor condition with wheelchair tracks and tears throughout the room, which was a safety hazard. -She made the decision that the carpet needed to be changed and spoke with the resident's Responsible Party to make him aware she was planning to have this work completed soon but that he would be made aware before the temporary move occurred. -When Resident #1 returned to the community, staff mistakenly moved her to another room prior to the ED speaking with the family member. -When the RP called to check on Resident #1 at her old room and could not get an answer, they were "rightfully upset" when they learned she had already been moved. -She called them immediately and apologized that Resident #1 had been moved before she had spoken with him again. -When her old room was ready for her to move back in, she had a conversation with the RP regarding her declining ambulatory status and discussed possibly moving her to the second floor instead. -The RP was agreeable to this and told her to "go ahead and move her to the second floor" which she had staff do in the day or so following their conversation. -She did not recall speaking with him further	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 156 about the move to the second floor being a problem. -She was not aware of the RP not being able to visit Resident #1 in her room on the second floor when he visited that Saturday. _____ The facility failed to ensure residents were free from neglect and their rights were upheld in regard to a resident who was made to wear a brief during the night because staff would not provide toileting assistance and was not permitted to choose her own bed time (Resident #13); a resident who was a two person transfer assist having to remain bed bound the majority of the time from April 2021 to the present due to staff being unable to assist her out of the bed without causing pain and fear (#9); a resident who was neglected when staff failed to provide oral care resulting in mouth sores, a thick black film in her mouth and difficulty eating due to pain and who was double briefed to reduce the number of times incontinent care was provided (Resident #7); an Assisted Living resident placed in the Special Care Unit (SCU) for supervision during the day and returned to the AL in the evening, which increased confusion and behaviors (Resident #5); a resident who had a physician's order dated April 2021 for SCU placement due to increased behaviors and confusion that had not been transferred to the higher level of care (Resident #6); two residents moved from their rooms without their or their responsible party's consent (Resident #1 and #6); call bells that would go unanswered for extended periods of time; and several residents' whose right to privacy was not enforced when wandering residents' entered their rooms at all hours of the day and night. The facility's failure placed the residents at serious neglect which constitutes a Type A2 Violation.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 338	Continued From page 157 The facility provided a plan of protection in accordance with G.S. 131D-34 on July 8, 2021 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 12, 2021.	D 338		
D 356	10A NCAC 13F .1003 (e) Medication Labels 10A NCAC 13F .1003 Medication Labels (e) Medications, prescription and non-prescription, shall not be transferred from one container to another except when prepared for administration to a resident. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a medication container contained only the medication listed on the medication label for 1 of 1 resident (Resident #18). The findings are: Review of Resident #18's current FL2 dated 05/18/21 revealed diagnoses included cerebrovascular accident (stroke), hypertension, and dementia. Review of Resident #18's signed physician orders dated 06/08/21 revealed there was an order for metoprolol ER 50mg, take one tab daily.	D 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 356	Continued From page 158 Observation of Resident #18's medications on hand on 07/08/21 at 10:03am revealed: -There was a medication bottle labeled with Resident #18's name and metoprolol ER 50mg. -The medication was dispensed by an outside pharmacy on 03/31/21. -Upon opening the bottle, most of the medication tablets were white but a few yellowish gold tablets were also visible in the bottle. -The medication was poured onto a medication counting tray; there were 37 white tablets and 4 yellowish gold tablets. Interview with a representative from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed: -The markings on the white tablets identified it as metoprolol ER 50mg. -The markings on the yellowish gold tablets identified it as nifedipine ER 60mg. Interview with the medication aide (MA) on 07/08/21 at 10:03am revealed: -She had no idea why there were two different colored tablets in Resident #18's metoprolol medication bottle. -When she administered medications, she compared the label on the bottle to the order in the electronic Medication Administration Record (eMAR). -She did not routinely look in the medication bottle prior to dispensing a tablet into the bottle lid and placing it in the medication cup. -She was not sure what color metoprolol ER 50mg was unless she researched it or saw the description on the bottle. -She could have and may have administered the incorrect medication to Resident #18.	D 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 356	Continued From page 159 Interview with Resident #18's Primary Care Provider (PCP) on 07/12/21 at 10:53am revealed she was unsure what possible outcomes could occur if Resident #18 were to receive nifedipine ER 60mg instead of metoprolol ER 60mg since they were both used to treat high blood pressure. Interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm revealed: -Resident #18's metoprolol ER 50mg bottle came with her when she was admitted at the end of May 2021. -When residents bring medications from home the medication in the medication bottles were not reviewed to ensure the correct medication was in the prescription bottle. Interview with the Executive Director (ED) on 07/12/21 at 4:44pm revealed: -She was unsure if medications brought from home were reviewed for accuracy. -She expected the medications brought from home to be reviewed by the nurses or the MAs to ensure the medication labeling was correct.	D 356		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 160 TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 2 of 4 residents observed during the medication pass received their medications as ordered by the primary care physician (PCP) including a medication used to treat depression, a medication used to prevent strokes (#14) and a medication used to lower cholesterol (#15). The facility failed to administer medications as ordered for 12 of 14 sampled residents related to two medications used to treat dementia (Resident #1), an antiseizure medication (Resident #2) and an antibiotic (Resident #3), a medication used to treat osteoporosis (Resident #6), a medication for depression (Resident #7 and #16), a bronchodilator used to relax muscles in the airways and increase air flow to the lungs (Resident #8), a medication used to treat glaucoma (Resident #11), two medications to control fluid buildup and a medication for nerve pain (Resident #12), medications used to treat high blood pressure (Resident #13, #17 and #18), medications used to treat and prevent blood clots (Resident #16, and #18), a medication used to treat atrial fibrillation (Resident #16), a medication used to treat underactive thyroid gland and two dietary supplements (Resident #16). The findings are: 1. The medication error rate was 14% as evidenced by the observation of 4 errors out of 27 opportunities during the 8:00am medication pass on 06/17/21. a. Review of Resident #14's current FL2 dated 02/24/21 revealed diagnoses included Alzheimer's disease, seizure and stroke.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 161 Review of Resident #14's Discharge Summary Clarification Form dated 03/02/21 revealed there was an order for citalopram 20mg, one tablet daily (a medication used to treat depression). Observation of the morning medication pass on 07/08/21 at 7:30am revealed: -The medication aide (MA) prepared 4 oral medications for Resident #14. -Citalopram was not administered to Resident #14. Observation of medications on hand for administration for Resident #14 on 07/08/21 revealed citalopram was not available for administration. Review of Resident #14's July 2021 electronic medication administration record (eMAR) revealed: -There was an entry for citalopram 20mg to be administered daily at 8:00am. -There was no documentation citalopram had been administered on 07/06/21 and on 07/07/21 and 07/08/21 it was documented not administered due to "awaiting pharmacy". Interview with the medication aide (MA) on 07/08/21 at 8:30am revealed: -She was the fulltime MA in the Special Care Unit (SCU). -She knew Resident #14 did not have any citalopram tablets in the facility. -She thought he had been out since 07/06/21. -She contacted the pharmacy on 07/06/21 for a refill of citalopram 20mg and was informed the refill could not be sent due to an "insurance issue.". -She had notified the Special Care Manager	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 162 (SCM). -She did not follow up with the family or the pharmacy since she could not resolve an insurance issue. -She did not contact the physician. -The process for refill of medications was the MA or the SCM should contact the pharmacy by phone or fax for the refill before the medication was completed. -If the family provided the medication, the MA or the SCM should contact the family. -She thought the MCM was following up on the medication because it was an insurance issue. Telephone interview with a representative from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed: -Resident #14's citalopram 20mg, 30 tablets were dispensed to the facility on 05/02/21. -They had not received any refill requests since the medication was dispensed on 05/02/21. -Based on the fill history, Resident #14's citalopram should have run out around 06/02/21. Interview with Resident #14's Primary Care Provider (PCP) on 07/12/21 at 10:53am revealed: -She was not notified Resident #14 did not receive citalopram as ordered. -She expected the facility to notify her of any refills needed and if a resident was not receiving medications as ordered. -Citalopram was a medication that should not be abruptly stopped. -Possible outcomes of Resident #14 not receiving citalopram 20mg as ordered included increased agitation and anxiety. Interview with the Resident Care Director (RCD) on 07/12/21 at 12:40pm revealed: -She had been in the position since April 2021.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 163	D 358		

-She was responsible for all medication orders in the assisted living and memory care units.
-She did not recall being informed of Resident #14's insurance issue regarding citalopram tablets.

Refer to the interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm.

Refer to the interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm.

Refer to the interview with the Executive Director (ED) on 07/12/21 at 4:44pm.

b. Review of Resident #14's Discharge Summary Clarification Form dated 03/02/21 revealed there was an order for clopidogrel 75mg, one tablet daily (an antiplatelet medication used to decrease the risk of heart disease and stroke).

Observation of the morning medication pass on 07/08/21 at 7:30am revealed:
-The MA prepared 4 oral medications for Resident #14.
-Clopidogrel was not administered to Resident #14.

Observation of medications on hand for administration for Resident #14 on 07/08/21 revealed clopidogrel was not available for administration.

Review of Resident #14's July 2021 eMAR revealed:
-There was an entry for clopidogrel 75mg to be administered daily at 8:00am.
-There was no documentation clopidogrel had been administered on 07/04/21 and from 07/06/21 to 07/08/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 164 Review of Resident #14's July 2021 medication notes revealed clopidogrel 75mg was not administered on 07/04/21 and from 07/06/21 to 07/08/21 due to "awaiting pharmacy". Interview with the MA on 07/08/21 at 8:30am revealed: -She did not know the clopidogrel was not available for administration. -She did not know the last time it was administered to Resident #14. -She had not requested a refill for clopidogrel and did not know if anyone else had. -There should be a note in the electronic communication or the Communication Log book in the medication room when the pharmacy was contacted for a refill. -She had not seen any documentation a refill for Resident #14's clopidogrel had been requested from the pharmacy. -The policy was to request refills for a resident's medication 7 days before the medication was completed. -That process was not always followed by the MAs. Interview with a representative from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed: -Resident #14's clopidogrel 75mg, 30 tablets were dispensed to the facility on 05/02/21. -Based on the fill history, Resident #14's clopidogrel should have run out around 06/02/21. Interview with Resident #14's Primary Care Provider (PCP) on 07/12/21 at 10:53am revealed: -She was not notified Resident #14 did not receive clopidogrel as ordered. -She expected the facility to notify her of any	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 165	D 358		

refills needed and if a resident was not receiving medications as ordered.
-Possible outcomes of Resident #14 not receiving clopidogrel as ordered included increased risk of blood clots that could lead to a stroke or death.

Interview with the Resident Care Director (RCD) on 07/12/21 at revealed:
-The MAs should be ordering refill medications 7 days prior to completion of the medication.
-This allowed the facility time to get new medication orders or to handle insurance issues without the resident missing scheduled doses.
-The MAs have been trained on this process several times since she had been in the position, but some MAs did not always follow the process.
-She did not know Resident #14 did not have clopidogrel available for administration during the morning medication pass on 07/08/21.

Refer to the interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm.

Refer to the interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm.

Refer to the interview with the Executive Director (ED) on 07/12/21 at 4:44pm.

C. Review of Resident #15's current FL2 dated 11/25/20 revealed:
-Diagnoses included dementia and prior brain hemorrhage (bleeding) due to trauma.
-There was an order for fish oil 1000mg daily (a medication used to lower triglycerides to lower risk of heart disease and stroke).

Observation of the morning medication pass on 07/08/21 at 7:30am revealed:
The medication aide (MA) prepared 5 oral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 166	D 358		

medications for Resident #15.
-There was an over the counter bottle of fish oil tablets labeled 1200mg.
-The MA placed the fish oil 1200mg into the medication cup to be administered to Resident #15.

Observation of medications on hand for administration for Resident #15 on 07/08/21 revealed fish oil tablets 1000mg were not available for administration.

Review of Resident #15's July 2021 eMAR revealed:
-There was an entry for fish oil 1000mg to be administered daily at 8:00am.
-Fish oil 1000mg was documented as administered from 07/01/21 through 07/08/21.

Interview with the MA on 07/08/21 at 8:30am revealed:
-The family provided the over the counter fish oil tablets.
-She did not receive this bottle from the family when they brought it to the facility.
-She assumed whoever received the fish oil tablets from the family checked the dosage.
-She thought the dosage was correct since it was already on the medication cart.
-She had not looked at the dosage on the bottle of fish oil before administering the tablets to Resident #15.

Interview with a representative from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed:
-Resident #15's fish oil 1000mg, 30 tablets were last dispensed to the facility on 03/11/21.
-Based on the fill history, Resident #15's fish oil should have run out around 04/11/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 167	D 358		

-Fish oil was available over the counter and the facility or a family member could have purchased the medication for Resident #15.
-The fish oil dosage administered to Resident #15 was not the dosage prescribed by the PCP.

Refer to the interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm.

Refer to the interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm.

Refer to the interview with the Executive Director (ED) on 07/12/21 at 4:44pm.

2. Review of Resident #16's current FL2 dated 04/12/20 revealed diagnoses included depression, lymphedema (swelling in the arms or legs due to build-up of lymph fluid), hypothyroidism (underactive thyroid gland), deep vein thrombosis (DVT) (blood clot) left leg, and atrial fibrillation (irregular heart rhythm).

a. Review of Resident #16's signed physician orders dated 06/24/21 revealed there was an order for digoxin 125mcg, one tablet every other day (used to treat atrial fibrillation).

Review of Resident #16's June 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for digoxin 125mcg, one tablet to be administered every other day at 8:00am.
-The digoxin entry had an "x" placed in every other day beginning 06/02/21, indicating Resident #16 was not to receive the medication that day.
-Digoxin was high-lighted yellow, indicating it was not administered, on 06/04/21, 06/06/21, 06/07/21, 06/08/21, 06/24/21, 06/26/21, 06/27/21,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 168	D 358		

06/29/21 and 06/30/21.
-Six of the nine high-lighted dates were dates Resident #16 was not to receive digoxin; 06/04/21, 06/06/21, 06/08/21, 06/24/21, 06/26/21 and 06/30/21.

Review of Resident #16's June 2021 medication notes revealed the reason digoxin 125mcg was not administered was it was on order from the pharmacy.

Interview with Resident #16 on 07/09/21 at 10:12am revealed she could identify some of the medications she took but was unsure if she always received her digoxin.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed:
-Resident #16's digoxin was not cycle filled and the facility needed to notify the pharmacy when refills were needed.
-The pharmacy dispensed Resident #16's digoxin 125mcg, 15 tablets on 06/08/21 and 15 tablets on 06/30/21.
-Based on the fill history, Resident #16 did not receive her digoxin as prescribed.
-Possible outcomes for Resident #16 not receiving her digoxin as ordered included increased risk of heart arrhythmias and increased risk of a heart attack.

Telephone interview with Resident #16's Primary Care Provider (PCP) on 07/09/21 at 1:02pm revealed:
-She expected Resident #16's medications to be administered as prescribed.
-She was not notified Resident #16 had missed doses of her digoxin.
-Digoxin was prescribed for Resident #16 to lower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 169	D 358		

her heart rate and help the heart pump better.
-Possible outcomes for Resident #16 not receiving her digoxin included increased risk of dizziness and passing out.

Interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm revealed:
-She did not know why Resident #16's digoxin had documentation on days it was not to be administered.
-She believed the digoxin should not even appear on the eMAR on days it was not to be given but now, was unsure.
-If it appeared on the eMAR on days it was not to be administered, it could cause medication errors.
-She was not aware MAs were documenting medication exceptions for the digoxin on days it was not to be administered.

Refer to the interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm.

Refer to the interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm.

Refer to the interview with the Executive Director (ED) on 07/12/21 at 4:44pm.

b. Review of Resident #16's signed physician orders dated 06/24/21 revealed there was an order for eliquis 2.5mg, one tablet twice daily (used to treat and prevent blood clots).

Review of Resident #16's June 2021 eMAR revealed:
-There was an entry for eliquis 2.5mg, one tablet to be administered twice daily at 8:00am and 7:00pm.
-There was no documentation eliquis was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 170	D 358		

administered from 06/13/21 to 06/26/21 except on 06/15/21 and 06/18/21 at 7:00pm and on 06/21/21 at 8:00am when it was documented as administered.

Review of Resident #16's June 2021 medication notes revealed the reason eliquis was not administered was it was on order from the pharmacy.

Interview with Resident #16 on 07/07/21 at 10:16am revealed:
-She could not identify all of her medications but she knew what eliquis looked like because it was small.
-The facility was out of her eliquis for about two and a half weeks and just received the refill last week.
-She takes eliquis because she is at risk for blood clots because she has atrial fibrillation.
-When she asked the medication aides (MA) about not receiving it she was told it was on order from the pharmacy.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed:
-Resident #16's eliquis was not cycle filled and the facility needed to notify the pharmacy when refills were needed.
-The pharmacy dispensed Resident #16's eliquis 2.5mg, 60 tablets on 05/01/21 and on 06/26/21.
-Based on the fill history, Resident #16 did not receive her eliquis as prescribed.
-Possible outcomes of Resident #16 not receiving her eliquis as ordered included increased risk of a stroke and more likely to develop another DVT.

Telephone interview with Resident #16's PCP on 07/09/21 at 1:02pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 171	D 358		

-She expected Resident #16's medications to be administered as prescribed.
-She was not notified Resident #16 had missed doses of her eliquis.
-Eliquis was prescribed for Resident #16 because she had atrial fibrillation and was at greater risk of developing blood clots.
-Possible outcomes for Resident #16 not receiving her eliquis included increased risk of a stroke and increased risk of another DVT.

Refer to the interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm.

Refer to the interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm.

Refer to the interview with the Executive Director (ED) on 07/12/21 at 4:44pm.

c. Review of Resident #16's signed physician orders dated 06/24/21 revealed there was an order for levothyroxine 75mcg, one tablet daily (used to treat hypothyroidism).

Review of Resident #16's June 2021 eMAR revealed:
-There was an entry for levothyroxine 75mcg, one tablet to be administered daily at 8:00am.
-There was no documentation levothyroxine was administered from 06/14/21 to 06/26/21 except on 06/20/21 and 06/25/21 when it was documented as administered.

Review of Resident #16's June 2021 medication notes revealed the reason levothyroxine was not administered was it was on order from the pharmacy.

Interview with Resident #16 on 07/09/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 172 10:12am revealed she could identify some of the medications she took but was unsure if she always received her levothyroxine. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed: -Resident #16's levothyroxine was not cycle filled and the facility needed to notify the pharmacy when refills were needed. -The pharmacy dispensed Resident #16's levothyroxine 75mcg, 30 tablets on 04/13/21 and on 06/26/21. -Based on the fill history, Resident #16 did not receive her levothyroxine as prescribed. -Possible outcomes of Resident #16 not receiving her levothyroxine as ordered included increased fatigue, constipation and muscle aches. Telephone interview with Resident #16's PCP on 07/09/21 at 1:02pm revealed: -She expected Resident #16's medications to be administered as prescribed. -She was not notified Resident #16 had missed doses of her levothyroxine. -Possible outcomes for Resident #16 not receiving her levothyroxine included decreased alertness and constipation. Refer to the interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm. Refer to the interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm. Refer to the interview with the Executive Director (ED) on 07/12/21 at 4:44pm. d. Review of Resident #16's signed physician	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 173	D 358		

orders dated 06/24/21 revealed there was an order for magnesium 400mg, one tablet at bedtime (used to treat low magnesium levels in the blood).

Review of Resident #16's June 2021 eMAR revealed:
-There was an entry for magnesium 400mg, one tablet to be administered daily at 7:00pm.
-There was no documentation magnesium was administered from 06/07/21 to 06/26/21 except on 06/15/21 and 06/18/21 when it was documented as administered.

Review of Resident #16's June 2021 medication notes revealed the reason magnesium was not administered was it was on order from the pharmacy.

Interview with Resident #16 on 07/09/21 at 10:12am revealed she could identify some of the medications she took but was unsure if she always received her magnesium.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed:
-Resident #16's magnesium was not cycle filled and the facility needed to notify the pharmacy when refills were needed.
-The pharmacy dispensed Resident #16's magnesium 400mg, 30 tablets on 04/13/21 and on 06/26/21.
-Based on the fill history, Resident #16 did not receive her magnesium as prescribed.
-Possible outcomes of Resident #16 not receiving her magnesium as ordered included nausea, vomiting and weakness.

Telephone interview with Resident #16's PCP on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 174 07/09/21 at 1:02pm revealed: -She expected Resident #16's medications to be administered as prescribed. -She was not notified Resident #16 had missed doses of her magnesium. -Resident #16 was prescribed magnesium because it was often prescribed along with potassium. -Possible outcomes for Resident #16 not receiving her magnesium included fatigue. Refer to the interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm. Refer to the interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm. Refer to the interview with the Executive Director (ED) on 07/12/21 at 4:44pm. e. Review of Resident #16's signed physician orders dated 06/24/21 revealed there was an order for potassium 10meq, two tablets daily (used to treat low potassium levels in the blood). Review of Resident #16's June 2021 eMAR revealed: -There was an entry for potassium 10meq, two tablets to be administered daily at 8:00am. -There was no documentation potassium was administered from 06/12/21 to 06/26/21 except on 06/20/21 when it was documented as administered. Review of Resident #16's June 2021 medication notes revealed the reason potassium was not administered was it was on order from the pharmacy. Interview with Resident #16 on 07/09/21 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 175 10:12am revealed she could identify her potassium tablet but was unsure if she always received it. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed: -Resident #16's potassium was not cycle filled and the facility needed to notify the pharmacy when refills were needed. -The pharmacy dispensed Resident #16's potassium 10meq, 60 tablets on 04/13/21 and on 06/26/21. -Based on the fill history, Resident #16 did not receive her potassium as prescribed. -Possible outcomes of Resident #16 not receiving her potassium as ordered included nausea, vomiting and weakness. Telephone interview with Resident #16's PCP on 07/09/21 at 1:02pm revealed: -She expected Resident #16's medications to be administered as prescribed. -She was not notified Resident #16 had missed doses of her potassium. -Resident #16 was prescribed magnesium because it was often prescribed along with potassium. -Possible outcomes for Resident #16 not receiving her potassium included weakness, fatigue, and irregular heart rhythm. Refer to the interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm. Refer to the interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm. Refer to the interview with the Executive Director (ED) on 07/12/21 at 4:44pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 176 f. Review of Resident #16's signed physician orders dated 06/24/21 revealed there was an order for trazodone 50mg, one tablet at bedtime (used to treat depression). Review of Resident #16's June 2021 eMAR revealed: -There was an entry for trazodone 50mg, one tablet to be administered daily at 8:00pm. -There was no documentation trazodone was administered from 06/01/21 to 06/26/21 except on 06/04/21 and 06/24/21 when it was documented as administered. Review of Resident #16's June 2021 medication notes revealed the reason trazodone was not administered was it was on order from the pharmacy. Interview with Resident #16 on 07/09/21 at 10:12am revealed: -She could identify some of the medications she took but was unsure if she always received her trazodone. -The medication aides (MA) told her she gets trazodone for sleep but she was unsure if she received it. -She had difficulty sleeping most nights in June 2021. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed: -Resident #16's trazodone was not cycle filled and the facility needed to notify the pharmacy when refills were needed. -The pharmacy dispensed Resident #16's trazodone 50mg, 30 tablets on 04/13/21 and on 06/26/21.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 177 -Based on the fill history, Resident #16 did not receive her trazodone as prescribed. -Possible outcomes of Resident #16 not receiving trazodone as ordered included insomnia and increased tiredness. Telephone interview with Resident #16's PCP on 07/09/21 at 1:02pm revealed: -She expected Resident #16's medications to be administered as prescribed. -She was not notified Resident #16 had missed doses of her trazodone. -Possible outcomes for Resident #16 not receiving her trazodone included increased tiredness and anxiety. Refer to the interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm. Refer to the interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm. Refer to the interview with the Executive Director (ED) on 07/12/21 at 4:44pm. 3. Review of Resident #18's current FL2 dated 05/18/21 revealed diagnoses included cerebrovascular accident (stroke), hypertension, and dementia. a. Review of Resident #18's signed physician orders dated 06/08/21 revealed there was an order to discontinue eliquis (a medication used to treat and prevent blood clots) and start pradaxa 150mg, one capsule twice daily (a medication used to treat and prevent blood clots). Review of Resident #18's June 2021 electronic medication administration record (eMAR) revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 178 -There was an entry for eliquis 2.5mg, one tablet twice daily at 9:00am and 9:00pm. -The eliquis entry was marked as discontinued on 06/09/21. -The last documented administration of eliquis was 06/09/21 at 9:00am -There was an entry dated 06/09/21 for pradaxa 150mg, one capsule twice daily at 8:00am and 8:00pm. -There was no documentation pradaxa was administered from 06/10/21 to 06/30/21 except on 06/10/21 when it was documented as administered one time at 8:00am. Review of Resident #18's June 2021 medication notes revealed: -There were 41 documented instances Resident #18's pradaxa was documented as not available to administer. -Documented reasons the pradaxa was not available included 'awaiting pharmacy', 'on order', 'not available pending deliver from pharmacy', not available', 'medication not covered by insurance', 'insurance rejecting medication'. -There was no documentation Resident #18's PCP was notified. Review of Resident #18's July 2021 eMAR revealed: -There was an entry for pradaxa 150mg, one capsule twice daily at 8:00am and 8:00pm. -There was no documentation pradaxa was administered from 07/01/21 to 07/08/21. Review of Resident #18's July 2021 medication notes revealed: -Documented reasons the pradaxa was not available include 'on order', 'medication not covered by insurance', 'not available, pending delivery from insurance' and 'not available, will	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 179	D 358		

contact pharmacy'.
-On 07/08/21 there was documentation the physician would be contacted.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed:
-The pharmacy received the order to discontinue Resident #18's eliquis and start pradaxa 150mg one capsule twice daily on 06/09/21.
-The pharmacy was notified by the insurance company on 06/09/21 there would be a high co-pay for the pradaxa, and they made the facility aware at that time.
-The pharmacy attempted to reprocess the medication authorization several times, with the same results.
-Resident #18's pradaxa had not been dispensed to the facility.
-It was the facility's responsibility to notify the PCP regarding the pradaxa not being dispensed.
-Both pradaxa and eliquis are blood thinning medications and decrease the risk of a stroke.
-Resident #18 was at a greater risk of stroke because she was not receiving either medication.

Interview with Resident #18's Primary Care Provider (PCP) on 07/12/21 at 10:53am revealed:
-She was not notified Resident #18 was not receiving her blood thinning medication.
-Resident #18 had atrial fibrillation, an irregular heart rhythm that increased the risk of a blood clot that could cause a stroke or death.
-Without receiving blood thinning medication, Resident #18's risk of a blood clot was further increased.
-She expected to be notified immediately if a resident's blood thinning medication was not available for administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 180	D 358		

Interview with a medication aide (MA) on 07/08/21 at 8:35am revealed:
-Resident #18's pradaxa was being rejected by the insurance company.
-She had been alerting the Resident Care Director (RCD) daily Resident #18's pradaxa was not available on the cart.
-The MAs were responsible for contacting the pharmacy for routine medication refills, but the RCD was responsible for contacting the pharmacy for any other medication issues.
-The RCD was responsible for notifying the PCP if medications were denied by the insurance company.

Refer to the interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm.

Refer to the interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm.

Refer to the interview with the Executive Director (ED) on 07/12/21 at 4:44pm.

b. Review of Resident #18's signed physician orders dated 05/28/21 revealed an order for hydralazine 25mg, one tablet three times daily (a medication used to treat high blood pressure).

Review of Resident #18's June 2021 eMAR revealed:
-There was an entry for hydralazine 25mg, one tablet three times daily at 9:00am, 4:00pm and 9:00pm.
-There was no documentation hydralazine was administered on 06/30/21.

Review of Resident #18's June 2021 medication notes revealed:
-Hydralazine was not administered because it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 181	D 358		

was on order from the pharmacy and not available.
-There was no documentation Resident #18's PCP was notified.

Review of Resident #18's July 2021 eMAR revealed:
-There was an entry for hydralazine 25mg, one tablet three times daily at 9:00am, 4:00pm and 9:00pm.
-There was no documentation hydralazine was administered from 07/01/21 to 07/07/21 except on 07/05/21 at 9:00pm, 07/06/21 at 4:00pm and 9:00pm and 07/07/21 at 4:00pm and 9:00pm when it was documented as administered.

Review of Resident #18's July 2021 medication notes revealed:
-Hydralazine was not administered because it was on order from the pharmacy and not available.
-There was no documentation Resident #18's PCP was notified.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed:
-Resident #18's hydralazine was not cycle filled and the facility needed to notify the pharmacy when refills were needed.
-The pharmacy dispensed Resident #18's hydralazine 25mg, 90 tablets on 05/29/21 and 07/06/21.
-Based on the fill history, Resident #18 did not receive her hydralazine as prescribed.
-Possible outcomes of Resident #18 not receiving hydralazine as ordered included increased blood pressure and increased risk of a heart attack.

Refer to the interview with the Resident Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 182 Director (RCD) on 07/12/21 at 2:00pm. Refer to the interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm. Refer to the interview with the Executive Director (ED) on 07/12/21 at 4:44pm. 4. Review of Resident #17's current FL2 dated 12/28/20 revealed: -Diagnoses included cerebrovascular accident (stroke), hypertension, and dementia. -There was an order for nifedipine ER 60mg, one tablet daily (used to treat high blood pressure). Review of Resident #17's July 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for nifedipine ER 60mg, one tablet daily at 9:00am. -There was no documentation nifedipine ER was administered on 07/06/21, 07/08/21 and 07/09/21. Review of Resident #17's July 2021 medication notes revealed: -Nifedipine was not administered because it was on order from the pharmacy and not available. -There was no documentation Resident #18's PCP was notified. Observation on 07/08/21 at 10:09am of medications on hand for Resident #17 revealed there was no nifedipine ER 60mg available for administration. Interview with a medication aide (MA) on 07/08/21 at 10:03am revealed: -She was not able to administer nifedipine ER 60mg to Resident #17 that morning because it	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 183	D 358		

was none available.
-She informed the HWD on 07/06/21 the nifedipine was not available.
-The HWD director was responsible to reorder Resident #17 medications because the resident changed pharmacies approximately two weeks ago and the MAs could not reorder medications from the new pharmacy.

Telephone interview with a representative from an outside pharmacy on 07/13/21 at 10:17am revealed:
-Nifedipine ER 60mg, 90 tablets were dispensed on 05/14/21 for Resident #17.
-Based on fill history, nifedipine should have been available for administration until 08/14/21.

Attempted interview with Resident #17 on 07/08/21 at 10:25am was unsuccessful.

Attempted telephone interview with Resident #17 PCP on 07/13/21 at 1:28pm was unsuccessful.

Refer to the interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm.

Refer to the interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm.

Refer to the interview with the Executive Director (ED) on 07/12/21 at 4:44pm.

5. Review of Resident #1's most recent FL2 dated 05/20/21 revealed diagnoses included hypertension, dementia and anxiety.

Review of Resident #1's signed physician orders dated 05/20/21 revealed there was an order formemantine 10mg, one tablet daily at bedtime (a medication used to treat dementia).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 184 Review of Resident #1's April 2021 eMAR revealed: -There was an entry for memantine 10mg, one tablet daily at 8:00pm. -There was no documentation memantine was administered 14 days in April 2021; 04/05/21, 04/07/21, 04/09/21, 04/10/21, 04/12/21, 04/14/21, 04/15/21, 04/17/21, from 04/19/21 to 04/23/21 and 04/26/21. Review of Resident #1's April 2021 medication notes revealed: -Memantine 10mg was not administered because it was on order from the pharmacy and not available, except on 04/26/21 when Resident #1 was at the hospital. -There was no documentation Resident #1's PCP was notified. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/09/21 at 3:13pm revealed: -Resident #1's memantine was not cycle filled and the facility needed to notify the pharmacy when refills were needed. -The pharmacy dispensed Resident #1's memantine 10mg, 30 tablets on 02/23/21 and on 04/23/21. -Based on the fill history, Resident #1 did not receive her memantine as prescribed. -Possible outcomes of not receiving memantine as ordered included increased memory loss and decreased cognition. Interview with Resident #1's Primary Care Provider (PCP) on 07/12/21 at 10:53am revealed: -Her office was not notified Resident #1 did not receive memantine as ordered. -She expected the facility to notify her or her	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 185	D 358		

office of any refills needed and if a resident was not receiving medications as ordered.
-Possible outcomes of Resident #1 not receiving memantine as ordered included more rapid decline in her cognition.
6. Review of Resident #2's current FL2 dated 05/07/21 revealed:
-Diagnoses included, dementia, hypertension, hypothyroidism, general debility and convulsions/seizures.
-There was an order for levetiracetam 250mg (a medication used to treat seizures) two times a day.

Review of Resident #2's Resident Register signature page revealed an admission date of 05/07/21.

Review of Resident #2's electronic Medication Administration Record (eMAR) for May 2021 revealed there was an entry for levetiracetam 250mg two times a day documented as not administered on 05/27/21 at 10:03pm, 05/28/21 at 8:38pm, 05/29/21 at 8:31am, and 05/30/21 at 8:58am.

Interview with a pharmacist with the facility's contracted pharmacy on 07/07/21 at 4:25pm revealed:
-There was an order for levetiracetam 250mg two times a day dated 05/07/21 in their system.
-The levetiracetam 250mg two times a day, was filled and 60 tablets, a 30 day supply, was dispensed on 05/27/21.
-The levetiracetam could not be filled on 05/07/21 because another pharmacy had filled it on 05/07/21 and insurance would not cover a fill of the levetiracetam.
-The levetiracetam 250mg, two times a day filled and dispensed at the other pharmacy was for 60

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 186	D 358		

tablets, a 30 day supply.
-According to the records, Resident #2 had enough levetiracetam to get Resident #2 through until 07/06/21 without running out.
-There were no other requests for levetiracetam from the facility staff.
-Resident #2 was removed from their system on 06/01/21.

Telephone interview with Resident #2's Power of Attorney (POA) on 07/08/21 at 4:30pm revealed:
-Resident #2 received levetiracetam 250mg two times a day for seizures.
-All of Resident #2's medications were supplied by an outside pharmacy upon admission and had enough to get Resident #2 through until the facility's contracted pharmacy could supply refills after admission.
-Resident #2's primary physician completed the FL2 with all of Resident #2's current medication before leaving from another state to come to this facility.
-She did not receive any notifications from the facility staff, she assumed all of the medications the physician prescribed were administered as ordered.
-She expected the facility staff to administer the levetiracetam as ordered to prevent recurrent seizures.

Telephone interview with Resident #2's previous Neurologist on 07/09/21 at 4:00pm revealed:
-Resident #2 was prescribed levetiracetam for seizures.
-Because Resident #2 was sensitive to the medication which caused falls, he decreased her dosage to the lowest amount possible and maintained most control over the seizures.
-If Resident #2 did not receive the levetiracetam as ordered then it put Resident #2 at an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 187 increased risk of the seizures to increase. Telephone interview with the previous Special Care Manager (SCM) on 07/13/21 at 10:15am. -She was not aware Resident #2 was not receiving her levetiracetam as ordered. -Resident #2 had levetiracetam on the medication cart from another pharmacy and should have gotten Resident #2 through until the facility contracted pharmacy could refill the medication. -The medication aide (MAs) were responsible for ensuring medications were administered as ordered. -The MAs were responsible for making sure the medications were on hand and if not, then the MAs were responsible for contacting the pharmacy. -The MAs were responsible for checking the overflow medications that were kept in the nursing office prior to notifying the pharmacy. -After the MAs notified the pharmacy and there still was an issue then the MAs were to notify her. -She was responsible for resident record and medication cart audits prior to May 2021 but there were so many issues with missing medications, orders, and required documents the ED brought in a Regional representative and agency nurses were to perform the weekly and monthly audits. Telephone Interview with the Health and Wellness Director (HWD) on 07/13/21 at 1:19 revealed: -She was not aware Resident #2 was not getting the levetiracetam as ordered. -The MAs were responsible for notifying the pharmacy to find out why. Refer to interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm. Refer to interview with the Health and Wellness	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 188 Director (HWD) on 07/12/21 at 2:50pm. Refer to interview with the Executive Director (ED) on 07/12/21 at 4:44pm. 7. Review of Resident #8's current FL2 dated 05/06/21 revealed: -Diagnoses included, heart failure, chronic kidney failure, aneurysm of the heart, and intracardiac thrombosis. -There was an order for Ipratropium 0.5mg-Albuterol 3mg/3ml (Duoneb, used to relax muscles around the airways to make it easier to breath) two times a day. -There was an order for continuous oxygen at 4 liters via nasal cannula. Review of Resident #8's Hospice Comprehensive Assessment and Plan of Care Update Report dated 06/01/21 revealed: -Diagnoses included, heart failure, dependence on supplemental oxygen, aneurysm of the heart, atherosclerosis heart disease of the coronary artery, chronic obstructive pulmonary disease, solitary pulmonary nodular and intracardiac thrombosis. -There was an order for Duoneb nebulization solution scheduled for two times a day and two times a day as needed for shortness of breath and wheezing. Review of Resident #8's May 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Duoneb two times a day documented as not administered on 05/15/21 and 05/16/21 due to "on order", 05/17/21 and 05/18/21 due to "machine on order", 05/21/21, 05/25/21, and 05/29/21 due to "not available, will contact pharmacy".	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 189	D 358		

-There was an entry for Duoneb two times a day were left blank on 05/01/21 to 05/14/21 at 9:00am and 9:00pm.
-Duoneb was documented as not administered 33 out of 50 opportunities.

Review of Resident #8's June 2021 eMAR revealed:
-There was an entry for Duoneb two times a day documented as not administered on 06/19/21 at 9:00am and 9:00pm due to "on order", 06/21/21 at 9:00am and 9:00pm due to "not available", 06/24/21 to 06/26/21, due to "waiting on pharmacy", and 06/28/21 to 06/30/21 at 9:00am and 9:00pm due to "awaiting refill", "not available" and "awaiting pharmacy".
-There was an entry for Duoneb two times a day were left blank on 06/08/21, 06/15/21 and 06/08/21 at 9:00pm.
-Duoneb was documented as not administered 19 out of 60 opportunities.

Review of Resident #8's July 2021 eMAR revealed:
-There was an entry for Duoneb two times a day documented as not administered on 07/05/21 at 9:00am and 9:00pm due to "need new cord".
-Duoneb was documented as not administered 2 out of 14 opportunities.

Observation of Resident #8's medications on hand revealed:
-On 07/08/21 at 9:15am, there were 14 doses of the Duoneb located on the medication cart.
-On 07/09/21 at 12:05pm, there was 1 unopened box of Duoneb dated 05/14/21 with 30 doses and 1 opened box of Duoneb dated 05/14/21 with 25 doses of Duoneb located in the medication room cabinet.
-The total Duoneb doses on hand were 69 out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 190 the 360 doses dispensed by the pharmacy. Interview with a medication aide (MA) on 07/08/21 at 9:16am revealed: -She was an agency MA and had worked at the facility for a month. -She was trained by another MA at the facility on the policies and procedures, and the way the facility did things. -She administered the Duoneb treatments to Resident #8. -Resident #8 was out of the Duoneb treatments the end on June 2021 when she was working on that hall. -She could not find any other Duoneb medications so she marked the eMAR as "awaiting refill" just like the other MAs did. -She notified the MA who was training her and a nurse that the medication was out. -She thought they had handled it, because one day there was medication on the medication cart. -She was told to notify the other MA with any issues because only the MA who was facility staff could notify the pharmacy. Interview with a pharmacist with the facility's contracted pharmacy on 07/08/21 at 10:45am revealed: -There was an order for Duoneb two times a day dated 05/06/21. -There was a notation in Resident #8's profile that Resident #8 had some Duoneb from the last facility and a refill was not requested until 05/14/21. -On 05/14/21 the Duoneb was filled and 360 doses, a 30 day supply, was dispensed. -There were no new requests for refill after 05/14/21. -Resident #8 would have run out of medication if given as ordered on 06/14/21.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 191 Interview with Resident #8 on 07/07/21 at 9:20am revealed: -He was prescribed Duoneb breathing treatments two times a day. -After he was admitted he did not receive his Duoneb treatments every day, two times a day as prescribed. -The staff would bring his oral medications and forgot the Duoneb. -Staff would say they would return with the Duoneb but would not return. -He was also told the medication was not delivered from the pharmacy or the nebulizer machine needed new parts like filter or face mask. -He was on oxygen at 4 liters via nasal cannula continually and he breaths easier after the breathing treatment. -He told the MA soon after admission to the facility and was informed then the pharmacy had not sent them. -He told a MA that he brought some with him from the other facility and questioned why could not have them. -The MA told him she "would see", she did not bring any back so he figured he could not use those breathing treatments for what ever reason. -When he walked to the bathroom in his room, while wearing his oxygen and he was out of breath by the time he got there. Interview with Resident #8 Power of Attorney (POA) on 07/07/21 at 9:20am revealed: -Resident #8 had not received his breathing treatment correctly since admitted to the facility. -Resident #8 informed him many times that he did not receive his breathing treatment on multiple occasions since admissions. -Resident #8 informed him the staff were aware.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 192 -He did not know why the medications were not being administered because Resident #8 had at least a weeks worth when he arrived at the facility to use until the new pharmacy took over. -He asked the MA working around the end of May 2021 about Resident #8 not getting the Duoneb and the MA informed him the Duoneb was now available. -He expected the facility to administer the breathing treatments as ordered so Resident #8 would not be out of breath so much. Interview with Resident #8's Hospice nurse on 07/09/21 at 9:00am revealed: -She was not aware Resident #8 was not receiving his Duoneb as ordered. -Prior to Resident #8's admission to the facility on 05/06/21, Resident #8 was independent. -Resident #8 required oxygen at 2-4 liters per minute via nasal cannula on a continuous basis. -Resident #8 was diagnosed with several heart and lung issues which made it hard for him to breathe without the correct medications such as his oxygen and the Duoneb treatments. -One of those diagnoses was Chronic Obstructive Pulmonary Disease (COPD) which Resident #8 was just admitted to the hospital for prior to coming to the facility. -Duoneb was effective and if the medication was not given as ordered then, Resident #8 could go back into a COPD exacerbation. -Resident #8's biggest problem right now was difficulty breathing. -The Duoneb treatments open up the airways in the lungs so the continuous oxygen could get into his lungs. -She expected the facility staff to administer the Duoneb treatments as ordered because if not, then Resident #8's lungs could tighten up and make it harder to breathe and could lead to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 193 another COPD exacerbation which could lead to death. Telephone interview with the Health and Wellness Director (HWD) on 07/13/21 at 2:00pm revealed: -She did not know Resident #8 was not receiving his medications as prescribed. -The MAs were responsible for administering Resident #8's Duoneb's as ordered to prevent respiratory issues. Refer to interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm. Refer to interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm. Refer to interview with the Executive Director (ED) on 07/12/21 at 4:44pm. 8. Review of Resident #3's current FL2 with no date revealed diagnoses included Alzheimer's disease, nocturia related to benign prostate hyperplasia, diabetes, and bilateral lower extremity edema. Review of Resident #3's physician visit not dated 06/08/21 revealed: -Resident #3 was seen by his Primary Care Provider (PCP) for complaint of frequent urination and ongoing evaluation and management of chronic medical conditions. -Staff report Resident #3 was urinating more frequently, but they were unable to give an estimate of how often. -The plan provided by the PCP was an order to obtain a urinalysis to rule out a urinary tract infection as a possible cause for Resident #3's symptoms. Review of Resident #3's physician's orders dated	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 194 06/14/21 revealed an order to begin Cipro (an antibiotic) 250mg twice daily for seven days. Review of the Special Care Unit (SCU) communication log dated 06/30/21 revealed the MA documented Resident #3 was not feeling good. Review of Resident #3's June 2021 and July 2021 electronic Medication Administration Record (eMAR) revealed there was no order for Cipro 250mg twice daily for seven days. Observation of Resident #3's medications on hand on 07/08/21 at 8:45am revealed no Cipro 250mg tablets available for administration. Telephone interview with a representative at the facility's contracted pharmacy on 07/09/21 at 9:00am revealed Resident #3 did not have a physician's order for Cipro 250mg and Cipro 250mg was never dispensed. Telephone interview with Resident #3's PCP on 07/08/21 at 3:45pm revealed: -She saw Resident #3 on 06/08/21 when staff reported the resident was urinating frequently. -She ordered a urinalysis to rule out a urinary tract infection. -On 06/14/21 after receiving Resident #3's positive urinalysis she ordered the Cipro twice daily for seven days. -She did not know Resident #3 did not receive his Cipro as ordered until today (07/08/21). -If Resident #3's urinary tract infection (UTI) was left untreated it could lead to an inflammation of the kidney due to bacterial infection, dehydration, electrolyte imbalances or urosepsis (an infection of the blood stemming from UTI).	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 195 Interview with the medication aide (MA) on 07/08/21 at 8:45am revealed: -Resident #3 was experiencing frequent urination. -She did not know Resident #3's PCP ordered Cipro 250mg twice daily for seven days. -If Resident #3 received an order for Cipro 250mg it was supposed be sent to the pharmacy and placed on his eMAR and delivered to the facility. -After the order was placed on the eMAR the MA or RCD could verify the order. -The HWD was responsible for ensuring the MAs were aware Resident #3 had an order for Cipro. -She was told the RCD and agency Registered Nurses (RN) were reviewing the residents' records to make sure no physician orders were overlooked. Interview with the RCD on 07/09/21 at 10:30am revealed: -She did not know Resident #3 was ordered Cipro 250mg twice daily for seven days. -She did not round on the residents with the physicians or receive report from them when they visited the residents twice weekly. -Sometimes she did not know Resident #3's PCP came to see him. -She did not get a copy of Resident #3's PCP visit notes. -Resident #3's PCP put all orders she wrote for Resident #3 in a folder. -She would check the folder for new orders and fax them to the pharmacy twice a week. -The MAs were expected to verify the medication orders and administer the medication. -On 06/04/21, she added Resident #3 to the list of residents to be seen by their PCP and wrote a progress note in Resident #3's record. -She did not follow up to make sure Resident #3 was seen by his PCP or if any new physician orders were provided after Resident #3 saw his	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 196 PCP. Interview with the Executive Director (ED) on 07/12/21 at 4:46pm revealed: -She expected the clinical staff which included the MAs, RCD, and HWD to make sure all physician orders were completed. -A representative from the corporate quality assurance team along with contracted agency nurses began auditing the residents' record for physician's orders, missing documents, and outdated required documentation since the end of May 2021. -She recognized physician orders were missing from resident's records. -She was still was working with the clinical staff to identify all the reasons the residents were not administered their medications and physician orders were overlooked. 9. Review of Resident #13's FL2 dated 03/20/19 revealed diagnoses of cerebral palsy and hypertension. Review of Resident #13's physician's orders signed 06/04/21 revealed an order for losartan potassium 50mg (used to treat high blood pressure),1 tablet daily. Review of Resident #13's May 2021 electronic Medication Administration Record (eMAR) revealed: -An entry for losartan potassium 50mg take 1 tablet daily scheduled at 8:00am. -Resident #13's losartan was documented as "medication not given" on 5 occasions, on: 05/24/21, 05/27/21, 05/28/21, 05/29/21, and 05/30/21. -There was no reason documented regarding why losartan 50mg was not administered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 358	Continued From page 197 Review of Resident #13's June 2021 eMAR revealed: -An entry for losartan potassium 50mg, take 1 tablet daily scheduled at 8:00am. -Resident #13's losartan was documented as "medication not given" on 17 occasions, on: 06/01/21, 06/02/21, 06/03/21, 06/05/21, 06/06/21, 06/07/21, 06/08/21, 06/09/21, 06/11/21, 06/12/21, 06/13/21, 06/14/21, 06/15/21, 06/16/21, 06/17/21, 06/18/21, and 06/21/21. -There was no reason documented regarding why losartan 50mg was not administered. Review of Resident #13's facility nursing progress notes revealed: -On 06/18/21, Resident #13's private aide reported her blood pressure medications had not been administered in awhile. -The eMAR was reviewed and the losartan potassium had not been administered since the beginning of June 2021. -Resident #13's blood pressure was documented as 142/90 and Resident #13 had no symptoms of high blood pressure. Telephone interview with a pharmacist with the facility's contracted pharmacy on 07/13/21 at 8:49am revealed: -The pharmacy dispensed a 30 day supply of losartan potassium on 04/06/21 and 06/21/21. -The original order was written in November 2020 and only had 6 refills. A new order was needed from Resident #13's physician prior to the 06/21/21 order being filled. -Losartan was usually prescribed to control high blood pressure and if not administered as ordered, it could result in heart attack or stroke. Telephone interview with Resident #13's Primary	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 198 Care Physician (PCP) on 07/13/21 at 9:20am revealed: -Losartan had been ordered to treat Resident #13's high blood pressure. -The facility had not notified him that Resident #13 had missed 5 doses of losartan in May 2021 and 17 doses in June 2021. -He expected her blood pressure to remain below 140/90 with her medications in place, however he was not concerned that staff had documented her blood pressure was 142/90 on 06/18/21. -Losartan was a maintenance medication for high blood pressure and going without this medication could result in Resident #13's blood pressure spiking and increase her risk of stroke. -His expected, that the facility would contact him immediately if there were any issues with administering the losartan. -Medication refills should be obtained timely, before Resident #13 ran out of her current stock. Interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm revealed: -She was not aware of Resident #13's losartan being missed for over 20 days in May 2021 and June 2021. -Her expectation was that MAs would inform her or another nurse at the facility and document the resident was out of medication on the eMAR and in the progress nursing notes so she or another nurse at the facility could follow-up with the physician. Interview with Health and Wellness Director (HWD) on 07/12/21 at 2:40pm revealed: -She was not aware of Resident #13's losartan was not administered as ordered in May 2021 and June 2021. -MAs had been directed to request refills when no less than 7 doses of a medication remained.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 358	Continued From page 199	D 358		

-When a refill of a medication had been requested, the request form was supposed to be flagged in the resident's record and the record should be placed on the counter for the RCD an agency nurse at the facility to review and follow-up, if needed.
-She and the RCD reviewed the MARs frequently to look for medications not administered.

10. Review of Resident #6's FL2 dated 07/07/20 revealed:
-Resident #6's diagnoses included diabetes mellitus type 2, hypertension, and dementia.
-Resident #6 did not have an order for alendronate 70mg.

Review of Resident #6's physician's office visit notes dated 09/18/20 with Rheumatologist revealed:
-Resident #6 had a diagnosis of postmenopausal osteoporosis (a progressive disease resulting in bone detoriation).
-A new medication order was written for alendronate 70mg (used to treat osteoporosis progression), administered by mouth once a week on an empty stomach with 8oz of water.

Review of Resident #6's physician's office visit notes dated 04/14/21 revealed the physician documented Resident #6 was supposed to be on alendronate once a week, but "that prescription was never picked up from the pharmacy".

Review of Resident #6's electronic communication between the physician and the Responsible Party (RP) dated 04/14/21 revealed:
-Resident #6's physician had communicated with the responsible party that her rheumatologist ordered alendronate and that she should have picked this up from the pharmacy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 200 Review of Resident #6's electronic communication between the RP and the physician dated 05/10/21 revealed: -Resident #6's responsible party responded to the previous message from the physician stating that she had been picking up the alendronate and delivering it to the facility, since September of 2020, when it was prescribed and she was under the impression that it had been administered as ordered until the physician's visit on 04/14/21. Review of Resident #6's electronic Medication Administration Record (eMAR) from September 2020 through April 2021 revealed there were no entries for alendronate 70mg. Review of Resident #6's May 2021 eMAR revealed there was an entry for alendronate sodium U-U 70mg tablet take 1 tablet once weekly was not documented on 05/07/21. Observation of Resident #6's medications on hand on 07/08/21 revealed: -The instructions for the alendronate sodium 70mg, was to take 1 tablet weekly on an empty stomach before breakfast, remain upright for 30 minutes and take with an 8oz glass of water. -There was a box of alendronate sodium 70mg dispensed on 03/02/21 containing 4 doses with an original order date of 09/18/20. -There was a second box of alendronate sodium 70mg dispensed on 03/02/21 containing 4 doses with an original order date of 09/18/20. -There was a third box of alendronate sodium 70mg dispensed on 10/16/20 containing 4 doses with an original order date of 09/18/20. -There was a fourth box of alendronate sodium 70mg dispensed on 11/12/20 containing 4 doses with an original order date of 09/18/20.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 201 -There were three boxes of alendronate sodium 70mg dispensed on 12/09/20 containing 4 doses in each box (12 doses total) with an original order date of 09/18/20. -There were 28 doses of alendronate sodium 70mg on hand, which was a seven month supply. Interview with RP on 06/25/21 at 2:30pm revealed: -Resident #6 was prescribed a new order of alendronate 70mg starting in September 2020. -Since it was prescribed, she had been picking up the order monthly. -Resident #6 had a physician's appointment on 04/14/21, which facility staff transported her to because she was not able to attend. -The physician discussed the order for alendronate 70mg that should have been administered to Resident #6 since September 2020. -The staff told the physician on 04/14/21 that they had not been made aware of the new order for alendronate and it had never been delivered to the facility by the RP or administered to Resident #6. -She did not give a prescription to facility staff, just the medication. -No staff had ever made her aware there was any problem with Resident #6's order for alendronate 70mg, any of the times she had delivered it to the facility. Telephone interview with Resident #6's Rheumatologist on 07/08/21 at 10:24am revealed: -She had prescribed alendronate 70mg to Resident #6 to treat osteoporosis to treat further bone loss which could lead to an increased risk of bone fracture. -The facility had never notified her that the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 202	D 358		

medication was not administered from September 2020 when it was originally ordered until May 2021.
-Resident #6 was at risk of further bone loss during the time she should have been taking alendronate 70mg from September 2020 to May 2021.

Interview with a medication aide (MA) on 07/08/21 at 9:15am revealed:
-She recalled seeing several boxes of alendronate 70mg in the second medication cart for Resident #6 and wondered why they had so many boxes of the medication since Resident #6 had not previously been taking the medication.
-It was not until a few months ago that the facility became aware that she had an order for alendronate 70mg and should have been taking it since September 2020.
-In the past, the medication would go in the clinic for the Resident Care Director (RCD) to follow-up on getting the order, but at some point it changed to putting the medication in the medication cart.
-She was not sure why the MAs had no follow-up to see why alendronate 70mg had continued to be delivered to the facility and was never administered.

Interview with a second MA on 07/08/21 at 9:30am revealed:
-Third shift used to be responsible for completing medication cart audits up until last month and should have found Resident #6's alendronate on the medication cart and not on the eMAR and questioned the missing order.
-In the past, new medications that they did not have a order for would have gone in the medication room but now they are supposed to go in the second medication cart.
-MAs had recently, in the past month, begun

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 203	D 358		

completing cart audits.
-To complete a medication cart audit, MAs were given a list of current medications for several residents and then they were supposed to go through the carts to verify that all medications currently ordered were on hand.
-Since the new medication for Resident #6 was in the second "overstock" medication cart, it would have been easy for this to have been overlooked for a while because the overstocked medication cart was not audited.
-She was not sure why no one had ever followed up on why Resident #6 was receiving this medication form the pharmacy since there was no order on file since 09/2020.
-She made the suggestion to the RCD in the past for all new medication orders to have a copy of the order to be placed on the cart to help ensure no new orders were overlooked but so far, this had not been implemented.

Interview with RCD on 07/12/21 at 2pm revealed:
-She started working at the facility about 2 weeks ago.
-She was aware that Resident #6 had an order for alendronate that had been missed for several months after receiving the order from the physician during Resident #6's office visit on 04/18/21.
-The facility did not have a process in place, that she was aware of, for receiving medications for which they did not yet have a copy of the order for the medication on file in the resident's record.
-She thought putting medications on the medication cart without an order was not a good idea because it would be easy for the medication to be overlooked and not followed up on with the physician's office, and suspected that was what had happened with Resident #6's alendronate .
-A MA should have completed a medication cart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 204	D 358		

audit and found the medication and when it was compared to the eMAR, notice there was no entry for the medication on the eMAR and questioned the physician or pharmacy.
-Third shift was supposed to be conducting medication cart audits but she was not sure of that process and did not have time to implement a new process due to she was new and learning the policies and procedures of her job.

11. Review of Resident #11's current FL2 dated 08/11/20 revealed:
-Resident #11 had diagnoses of bipolar disorder, arthritis, sciatica, and insomnia.
-There was no order for eye drops listed on the FL2.

Interview with Resident #11 on 07/07/21 at 10:12am revealed:
-He had gone to the optometrist last week and had a new order for latanoprost (an eye drop used to treat glaucoma) that his Responsible Party (RP) had brought to the facility and given to the medication aide (MA) on Sunday, 07/04/21.
-He had not yet had any eye drops administered to him and "didn't know what was going on" with the new medication.
- When his RP gave the medication to the person at the front desk, they accepted the medication and said they would get the medication started.
-He had asked staff on Monday 07/05/21 about his new eye drops and they told him he needed to provide an order before staff could administer the latanoprost.
-He did not know where the eye drops were now but was aware they were supposed to be refrigerated.

Telephone interview with Resident #11's RP on 07/12/21:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 205 -She took Resident #11 to an optometrist appointment on 06/30/21. - She picked up a prescription of eye drops for Resident #11's newly diagnosed glaucoma and took them to the facility on Sunday, 07/04/21. -She gave the eye drops to the concierge but did not have an order to give with the medication. -She asked if she could speak to a nurse about the new prescription and he said would give it to the nurse, and if there were any issue with the new medications, someone would call her. -On Monday, 07/05/21, she spoke with Resident #11 and he said his eye drops had not been started yet and that staff had told him they needed an order for the eye drops. -She called the facility that same day, 07/05/21, but was unable to speak with anyone and had to leave a voicemail. She never received a call back that day. -On Tuesday, 07/06/21, she called and asked to speak with the manager on duty. -She was told she did not need to do anything else and they would make sure the eye drops were administered. -She spoke with Resident #11 on Thursday, 07/08/21, and he said the drops had still not been started. -She emailed the Executive Director (ED) that day about her concerns regarding his new eye drops. -She spoke with the Health and Wellness Director (HWD) later on Thursday, who said the issue had been resolved and that the facility was able to get a copy of the order for the eye drops from the pharmacy and that they would be started that day. -This was the first prescription medication she had ever brought from an outside physician and she was not aware she needed to bring an order with the medication. -She had specifically asked to speak with a nurse	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 206	D 358		

the day she brought the medication to the facility to be sure there was nothing else she needed to do at that time but she was not allowed to do so at that time.

Interview with medication aide (MA) on 07/08/21 at 9:15am revealed:
-She was working when Resident #11's responsible party had brought in the new latanoprost eye drops on Sunday, 07/04/21.
-The concierge brought them to her on the 3rd floor and then she took the eye drops down to the medication room and gave them to the agency nurse so she could follow up to obtain an order for the eye drops.
-She made a note in Resident #11's progress notes documenting the eye drops had been delivered and that she had given them to the nurse in the clinic because a copy of the order was needed.
-If it had been a weekday, she would have called the physician's office herself to request a copy of the medication order but since it was a weekend and a holiday, she did not attempt to do so.

Interview with third MA on 07/08/21 at 11:20am revealed:
-When a family member brought in a new prescription after taking a resident to the physician's office, she always called the pharmacy at which the prescription was filled and asked them to fax a copy of the original order to the facility for the resident's record.
-She would also let the Resident Care Director (RCD) know and would make a note in the resident's record that she had requested the order be faxed and that the medication was already on hand.
-A medication that was brought to the facility that they did not yet have a prescription for yet should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 207 never go on the cart but should instead be placed in the "overstock" cabinet in the medication room. Interview with a fourth MA on 07/08/21 at 11:30am revealed: -If a family member brought in a new medication for a resident, she would not accept it from the family member without a copy of the original order. -She would explain to them that they would need to obtain the order before they could accept the medication or administer it to the resident. Review of Progress Notes for Resident #11 revealed: -An entry dated 07/04/21 at 12:59pm, documented Resident #11's RP had "dropped off eye drops today but we did not have an order to administer the eye drops ...medication given to nurse to follow up with doctor." Interview with RCD on 07/12/21 at 2:00pm revealed: -She was not working on Sunday when Resident #11's family member brought his new eye drops to the facility. -The nurse who was working at the time the eye drops were delivered was probably not able to follow-up with the doctor's office or pharmacy because it was a holiday weekend. -The need for follow-up should have been documented so someone could have taken care of it first thing on Monday morning. -She had not seen the "general note" a MA had documented on 07/04/21, when the drops were received on 07/04/21, that documented the need for a copy of the order, and her communication with the nurse on duty at the time regarding Resident #11's eye drops. -Notes were supposed to be reviewed by one of	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 208 the nurses daily to assure any follow-up needed was completed. Interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:10 revealed: -She was not aware that Resident #11 had a new order for latanoprost eye drops that had been delivered to the facility on 07/04/21. -The same nurse was who received the eye drops on Sunday from the MA was also scheduled to work on Monday but called out sick and at that point, "the ball seems to have been dropped" and never followed up on. -She was not sure why no one saw the note the MA who received the eye drops had documented when the drops were delivered. The RCD or one of the other nurses was responsible for reviewing notes and following up as needed on orders. Interview with Executive Director (ED) on 07/07/21 at 4:45pm revealed: -She was not aware Resident #11 had an order for eye drops that was brought to the facility by the RP on 07/04/21 that had not yet been administered to him. -She depended on her clinical staff and regional support to assure compliance with assuring all medications that were supposed to be administered had orders in the facility, including new medications brought in from outside physician's appointments. -Staff were supposed to notify the RCD or the nurse on duty if there was a problem with a medication, such as an order needed, and they would follow-up with the physician or pharmacy to obtain the order. Refer to interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 358	Continued From page 209 Refer to interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm. Refer to interview with the Executive Director (ED) on 07/12/21 at 4:44pm. 12. Review of Resident #12's current FL2 dated 01/06/20 revealed: -Diagnoses included acute and chronic respiratory failure, chronic kidney disease, Type 2 diabetes, and primary hypertension. Review of a subsequent physician's order dated 02/12/21 revealed there was an order for torsemide 10mg, five tablets daily, (used to treat fluid overload) to be administered at 9:00am. Review of Resident #12's June 2021 electronic medication administration record (eMAR), from 06/01/21 through 06/30/21 revealed: -There was an entry for torsemide 10mg, five tablets daily to equal 50mg, to be administered at 9:00am. -Torsemide 10mg was documented as not administered 5 of 30 opportunities. -There was no reason documented for torsemide not administered from 06/07/21 though 06/11/21. Review of Resident #12's daily weights revealed; -Resident #12's weight on 06/07/21 was documented as 215 pounds (lbs). -Resident #12's weight on 06/08/21 was documented as 219 lbs. -Resident #12's weight on 06/09/21 was documented as 223 lbs. Observation of Resident #12's medications available for administration on 07/12/21 revealed: -There was a blister pack of torsemide 10mg, 5	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 210	D 358		

tablets daily, dated 04/12/21, 5 of 5 packs.
-The blister pack, labeled 5 of 5, had 30 individually wrapped tablets.
-There were no other blister packs available for administration.

Interview with Resident #12 on 07/09/21 at 12:20pm revealed:
-There were times he had been out of medications.
-He did not always question his medications when they were administered, however, if he did not receive his "water pill" due to his diagnoses of lymphedema, his legs would immediately begin to swell.
-He was administered 5 tablets of torsemide 10mg, to equal 50mg, daily.
-Sometime over the past few weeks the MA said they were out of the torsemide.
-If torsemide was not administered he could feel his legs swelling that next morning from fluid buildup.
-The MA reported sometimes the medications were not ordered until they were "out" and it took a little time to get it back in the building.
-He thought it happened with some of his other medications but he did not have the same overt symptoms he experienced with the torsemide.

Telephone interview with a representative from the facility's contracted pharmacy on 07/13/21 at 10:35am revealed:
-The staff should start the medication refill request process 7 days in advance, in the event there was a need for a new prescription from the PCP or there was an insurance issue, so the resident did not miss a scheduled dose.
-The staff had to call and re-order torsemide when needed.
-Torsemide was packaged in a 30 tablet blister

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 211	D 358		

pack, each tablet individually wrapped, each blister pack a 6 day supply.
-The fill history for torsemide 10mg was as follows: on 02/12/21, 300 tablets for a 60 day supply were sent; on 04/12/21, 150 tablets for a 30 day supply were sent; on 04/29/21, 70 tablets for a 14 day supply were sent and on 05/07/21, 150 tablets for a 30 day supply were sent.
-From 02/12/21 through 07/08/21, the pharmacy sent 670 tablets of torsemide 10mg 5 tablets daily.
-From 02/12/21 through 07/08/21 at 5 tablets daily, the facility should have administered 720 tablets of torsemide 10mg five tablets daily.

Interview with a medication aide (MA) on 07/12/21 at 10:47am revealed:
-She did not know why there were additional torsemide tablets for Resident #12.
-The tablets were individually wrapped and not multi-dosed.
-It was necessary to pop 5 individual tablets for the proper dosage.

Interview with the Health and Wellness Director (HWD) on 07/12/21 at 3:15pm revealed she did not know Resident #12 had missed several doses of his diuretic pill.

Interview with the Executive Director (ED) on 07/12/21 at 3:45pm revealed she did not know Resident #12 had missed several doses of his diuretic pill.

Attempted telephone interview with the Resident #12's Primary Care Provider (PCP) on 07/12/21 at 3:55pm was unsuccessful.

Refer to interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 212 Refer to interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm Refer to interview with the Executive Director (ED) on 07/12/21 at 4:44pm _____ Interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm revealed: -She was responsible for following up with new orders to ensure they were accurately placed in the eMAR system by the pharmacy. -She felt the medication order system needed work because medications were often not available for administration. -There was a system put into place at the end of May 2021 in which an order was flagged in the resident's record until it was completed, and the medication was available, but staff did not follow the process. -She tried to follow up on medication issues, such as insurance denials and medications not available, but there was no system. -She relied on her memory to follow up on medication concerns. -MAs were responsible to reorder resident medications when there were seven doses remaining. -The third shift MAs were responsible for medication cart audits, but she did not know what the process was. -There was no one reviewing the eMARs for medications not administered. Interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:50pm revealed: -She reviewed the residents' eMARs twice weekly for refusals, missed doses and correct orders. -There was color coding on the eMAR to indicate the reason a medication was not given.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 213 -The eMAR coding does not print in color, so the eMAR reviews have to be done on the computer. -She provided feedback to the clinical staff and MAs regarding documentation and problem solving around general medication questions. -The MAs should be requesting refills for medications 7 days before the medication has been completed. -This allows enough time to handle refill prescriptions and insurance issues if they occur. -If the medication was not in the building, one of the nurses would call the family and inform them. -If the family did not provide the medication, the clinical staff would try to get a discontinue order from the physician. -If it was a vital medication such as insulin, the facility paid for the medication and billed the family. -The pharmacy consultant had been providing quarterly cart audits. -Third shift staff were completing cart audits weekly, however she just drafted a new form for the first and second shift MAs to use for weekly cart audits. -The MAs were responsible for administering resident medications as ordered by the physician. -The MAs had several trainings since the beginning of June 2021 on how and when to order medications. -The nurses were responsible for reviewing resident eMARs every day for resident medications not administered and to follow up on any doses not administered. Interview with the Executive Director (ED) on 07/12/21 at 4:44pm revealed: -The the HWD and the RCD were responsible for overseeing that the physician orders and treatments were entered onto the eMAR correctly.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 214 -They were also responsible for cart audits and educating the MAs on the process for refill medications. -She expected the MAs to administer resident medications as ordered. -It was the responsibility of the MAs to reorder resident medications when there were seven doses remaining. -She expected the MAs to follow up with the pharmacy or the nurse if a medication was not available to administer. _____ The facility failed to ensure medications were administered as ordered by the licensed prescribing physician for 2 of 4 residents observed during the morning medication pass including a medication used to treat depression (Resident #14) and a medication to decrease cholesterol which can lead to strokes (Resident #15).The facility failed to administer medications as ordered for 12 of 14 sampled residents related to medications to thin the blood which could lead to an increased risk of stroke and death, (Resident #14, #16 and #18), medications to prevent high blood pressure which increased the risk for heart attacks and strokes (Resident #13 and #18), a medication for a urinary tract infection which left untreated could lead to urosepsis (Resident #3), a diuretic which caused an increase in lower leg swelling and possible skin breakdown (Resident #12), and a breathing treatment for shortness of breath which could lead to acute breathing difficulties (Resident #8). The facility's failure resulted in serious neglect and constitutes an A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on July 8, 2021 for this violation.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 358	Continued From page 215 THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 12, 2021.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the electronic medication administration record (eMAR) for 5 of 5 sampled residents (Resident #1, #2, #3, #4, and #5) related to no legend identifying medication aide's (MA) initials with their signature.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 367	Continued From page 216 1. Review of Resident #4's current FL2 dated 04/09/21 revealed: -Diagnoses included dementia with behavioral disturbance, history of falls and pain management. -There was a physician's order for tylenol 650mg twice a day, vitamin B12 1000mcg daily, vitamin C 500mg daily, vitamin D2 25mcg 4 tablets daily, aricept 10 mg daily, levothyroxine 75mg daily, zestril 2.5mg daily, namenda 10mg daily, bupropion XL 150mg twice daily, melatonin 3mg at bedtime, lipitor 20mg at bedtime, zoloft 100mg twice daily and an order for potassium chloride 8 MEQ daily. Review of Resident #4's June 2021 electronic Medication Administration Record (eMAR) from 06/01/21 through 06/30/21 and July 2021 eMAR from 07/01/21 through 07/09/21 revealed: -Each of the medications were documented as administered. -There were various initials documentating the administration of the medications. -There was no legend identifying who the staff initials belonged to. Refer to interview with the Executive Director on 07/08/21 at 10:10am. Telephone interview with the eMAR program representative on 7/12/21 at 12:50pm. Refer to telephone interview with the Health and Wellness Director on 07/13/21 at 1:46pm. 2. Review of Resident #3's current FL2 revealed: -There was no physician's signature and date. -Diagnoses included Alzheimer's disease, nocturia related to benign prostate hyperplasia,	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 367	Continued From page 217 diabetes, and bilateral lower extremity edema. Review of Resident #3's Resident Registrar revealed there no date of admission. Review of Resident #3's signed physician's orders dated 03/26/21 revealed: -There was a physician's order for tylenol 650mg every 6 hours PRN for pain, aspirin 81mg daily with food, atorvastatin calcium 20mg daily, B-12 1,000 mcg every other day with food, donepezil HCL 10mg every day, ferrous sulfate 325mg three times daily, furosemide 20mg every day, lisinopril 40mg every day, melatonin 3mg at bedtime, metformin HCL 1000mg twice daily, olanzapine 2.5mg at bedtime, olanzapine 2.5mg three times daily as needed for agitation, potassium 10meq daily with food, and tamsulosin HCL 0.4mg at bedtime. -There was a physician's order for blood pressure daily notify MD if >180 or <100 systolic or diastolic >100 or <50. -There was a physician's order for finger stick blood sugars twice daily notify MD if <60 or >400. -There was a physician's order for TED hose apply in the morning and remove at bedtime. -There was a physician's order for weekly weights document in computer vital signs. Review of Resident #3's June and July 2021 electronic Medication Administration Record (eMAR) revealed: -Each of the medications were documented as administered. -There were various initials documenting the administration of the medications. -There was no legend identifying who the staff initials belong. Interview with a medication aide (MA) on	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 367	Continued From page 218 07/13/21 at 10:50am revealed: -She recognized her initials on the paper copy of Resident #3's eMAR. -She did not know why there was not a legend on Resident #3's eMAR identifying her initials. -When she logged into Resident #3's eMARs she documented Resident #3's medications and treatments as administered on Resident #3's eMAR by clicking on them. Refer to interview with the Executive Director on 07/08/21 at 10:10am. Refer to telephone interview with the eMAR program representative on 07/12/21 at 12:50pm. Refer to telephone interview with the Health and Wellness Director (HWD) on 07/13/21 at 1:46pm. 3. Review of Resident #5's current FL2 dated 10/06/20 revealed diagnoses included dementia. Review of Resident #5's Resident Register revealed Resident #5 was admitted to the facility on 10/23/20. Review of Resident #5's signed physician's orders dated 06/15/21 revealed: -There was a physician's order for acetaminophen 1000mg twice daily, aspirin 81mg daily, donepezil HCL 5mg daily, hydrochlorothiazide 12.5mg daily, losartan potassium 25mg daily, atorvastatin 20mg daily, vitamin B-12 1000mcg daily, warfarin 4mg daily, and cyclobenzaprine HCL 10mg three times daily as needed. -There was a physician's order for blood pressure daily notify MD if >180 or <100 systolic or diastolic >100 or <50.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 367	Continued From page 219	D 367		

Review of Resident #5's June and July 2021 electronic Medication Administration Record (eMAR) revealed:
-There were staff initials for each of Resident #5's medications that was administered.
-There was documentation of staff initials on the date and time these medications were administered.
-There was no legend identifying who the staff initials belong.

Interview with a medication aide (MA) on 07/13/21 at 10:50am revealed:
-She recognized her initials on the paper copy of Resident #3's eMAR.
-She did not know why there was not a legend on Resident #3's eMAR identifying her initials.
-When she logged into Resident #5's eMARs she documented Resident #5's medications and treatments as administered on Resident #5's eMAR by clicking on them.

Refer to interview with the Executive Director on 07/08/21 at 10:10am.

Refer to telephone interview with the eMAR program representative on 07/12/21 at 12:50pm.

Refer to telephone interview with the Health and Wellness Director on 07/13/21 at 1:46pm.

4. Review of Resident #2's current FL2 dated 05/07/21 revealed:
-Diagnoses included, dementia, hypertension, hypothyroidism, general debility and convulsions/seizures.
-There was an order for levetiracetam 250mg two times a day; sertraline 25mg every day; levothyroxine sodium 100mcg every morning before breakfast; amlodipine besylate 2.5mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 220	D 367		

every day as need after blood pressure was checked; miralax 1 capful with juice or water every morning as needed, and a pain reliever 500mg ever 8 hours as needed for pain not to exceed 3000mg in 24 hours.

Review of Resident #2's May 2021 electronic Medication Administration Record (eMAR) revealed:
-The initials present included "AM", documented 26 out of 48 entries and there was no way to determine who's initials they were.
-The other initials were unidentifiable as to whom administered the medications.

Interview with a medication aide (MA) on 07/08/21 at 9:16am revealed:
-She identified "AM" as the initials she was assigned to use on Resident #2's eMARs.
-It was the same initials every agency staff member and new hires were to use.
-She was a new hire and had only been at the facility a month and had not received an access code to the computer that would correlate to her individuals initials.
-There was no way to look at the eMAR and tell who administered the medications by just initials, with no legend on the eMAR and with multiple people with the same generic initials "MA".

Refer to telephone interview with the eMAR program representative on 7/12/21 at 12:50pm.

Refer to telephone interview with the Health and Director on 07/13/21 at 1:46pm.

Refer to interview with the Executive Director on 07/08/21 at 10:10am.

5. Review of Resident #1's most recent FL2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 221 dated 05/20/21 revealed diagnoses included, dementia, hypertension, atrial fibrillation, and anxiety. Review of Resident #1's signed physician orders dated 05/20/21 revealed there were orders for amlodipine 5mg, one tablet daily, aspercreme 4% one application to bilateral knees daily as needed for pain, calcium outer UD chewable 500mg, one tablet daily, donepezil 10mg, one tablet at bedtime, I-vite 1000-60-2, one tablet daily, magic mouthwash 5ml three times daily as needed for mouth pain, mapap arthritis 650mg, one tablet every six hours as needed for pain, memantine 10mg, one tablet at bedtime, metoprolol 25mg, 0.5 tablet (12.5mg) daily, multivitamin with minerals, one tablet daily, and vitamin D-3 5000IU, one tablet daily. Review of Resident #1's May 2021 electronic Medication Administration Record (eMAR) revealed: -Each of the medications were documented as administered prior to Resident #1's discharge on 05/22/21. -There were various initials documenting the administration of the medications. -There was no legend identifying who the staff initials belonged to. Refer to telephone interview with the eMAR program representative on 7/12/21 at 12:50pm. Refer to interview with the Executive Director on 07/08/21 at 10:10am. Refer to telephone interview with the Health and Wellness Director on 07/13/21 at 1:46pm. --- Interview with the Executive Director on 07/08/21	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 367	Continued From page 222 at 10:10am revealed: -The MAs, both staff and agency, were responsible for using their login and password for the medications they administered. -She did not know the agency MAs and new hire MAs were using the same login and password. -The eMAR program they were using was not optimal to run different reports and they were in the process of obtaining a new program. -The Health and Wellness Director (HWD) was responsible for contacting the program representative to assign the login and password to the staff. Telephone interview with the eMAR program representative on 7/12/21 at 12:50pm revealed: -The facility had the capability of running a report for refusals or medication not administered. -Each employee should have a unique identity with a two factor identification including the staffs' phone number and email. -The facility would easily have the capability to match the initials of the staff with their personal information to identify the staffs' initials who administered the medication. -Agency staff may use the same log in but it was the facility's responsibility to keep record of what MA administered medications on certain days and times. -Their company could grant a new user identification upon request almost immediately. -Their staff was available for the facilities 24/7 and would administer trainings upon request. Telephone interview with the HWD on 07/13/21 at 1:46pm revealed: -Agency MAs were given the same login and password to the computer program by the representative of the program during their first day of work.	D 367		

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 367	Continued From page 223 -The Agency MAs used the same login and password. -There was no way to know who was administering the medications except by looking at the schedule of staff who worked that day. -She did not know the new staff were given the same login and password as the agency MAs. -The new staff were to be given their own individual login and password to match their initials. -With this eMAR documentation program there was no legend to compare the initials documented with the staff who administered the medication. -They were in the process of replacing this eMAR system with a new one that had everything built into the program such as signature lines.	D 367		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to follow up on a pharmacy recommendation for a decrease and discontinuation of a medication used to treat a major depressive disorder for 1 of 6 sampled residents (Resident #7). The findings are:	D 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 406	Continued From page 224 Review of Resident #7's current FL2 dated 02/03/21 revealed: -Diagnoses included dementia, mood disorder, anxiety and hypertension. -A handwritten note under "medications" "see attached list." -There was no list attached. Review of a subsequent physician's order dated 02/11/21 revealed there was an order for amitriptyline HCL 50mg, (used to treat a major depressive disorder), to be administered at bedtime. Review of Resident #7's April 2021 eMAR from 04/01/21 through 04/30/21 revealed: -There was an entry for amitriptyline HCL 50mg, 1 tablet at bedtime -Amitriptyline HCL 50mg was documented as administered at 9:00pm from 04/01/21 through 04/30/21. Review of Resident #7's May 2021 eMAR from 05/01/21 through 05/31/21 revealed: -There was an entry for amitriptyline HCL 50mg, 1 tablet at bedtime -Amitriptyline HCL 50mg was documented as administered at 9:00pm from 05/01/21 through 05/31/21. Review Resident #7's Pharmaceutical review dated 04/14/21 revealed: -Resident #7 was receiving Abilify 5mg daily, Trazadone 25mg daily and Amitriptyline 50mg daily. -The pharmacy reviw recommended a decrease in the amitriptyline 50mg to 25mg and eventually discontinuing the medication due to the BEER's recommendations (a reference tool used by the	D 406		

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 406	Continued From page 225	D 406		

American Geriatrics Society for potentially inappropriate medication use in older adults).
-The review included the primary care physician's (PCP) name and a place for her to sign to accept the following recommendations or decline with reasons noted.
-The entry for the PCP's signature, date and response was blank.

Telephone interview with Resident #7's primary care physician (PCP) on 07/12/21 at 12:30pm revealed:
-She visited the resident's at the facility, who she provided care for, weekly.
-She had never received the pharmacy review for Resident #7 dated 04/14/21.
-The facility had not notified her regarding the pharmacy recommendations to decrease the amitriptyline 50mg to 25mg daily and eventually to discontinue the medication based on the BEER's list of potentially harmful medications for elderly residents.
-She would have agreed with the consultation recommendation and decreased the amitriptyline 50mg to 25mg and eventually discontinued the medication.

Interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:20pm revealed:
-She assumed the HWD position at the end of April 2021.
-She did not receive the pharmacy review dated 04/14/21 for Resident #7.
-She did not know who did receive the pharmacy review report.
-The process should be as follows: the pharmacy review was sent to the Executive Director (ED) or the designee.
-The ED/designee sent the review to the PCP.
-The PCP approved or declined the

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 406	Continued From page 226 recommendation and returned the form to the facility. -If the recommendation was approved, a signed physician's order would be sent to the pharmacy. -The signed review would be placed in the resident's record. Interview with the ED on 07/12/21 at 3:15pm revealed: -She did not have any record of the April 2021 pharmacy reviews for the residents. -She did not know who was responsible for following up with the pharmacy quarterly reviews of the residents' medications. -She expected the clinical team, the HWD and the nursing staff, to follow up with any medications, treatments, and orders, including receiving and following up with the PCP's regarding recommendations from the pharmacy.	D 406		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter;	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 433	Continued From page 227 (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on interviews and record review the facility failed to maintain resident records in an orderly manner and readily available for review for 4 of 6 residents sampled (#2, #3, #4 and #7). The findings are: 1. Review of Resident #3's current FL2 revealed: -Diagnoses included Alzheimer's disease, nocturia related to benign prostate hyperplasia, diabetes, and bilateral lower extremity edema. -There was no physician's signature and date.	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 433	Continued From page 228 Review of Resident #3's Resident Register revealed there no date of admission. Review of Resident #3's new admission checklist revealed: -Resident #3 received an assessment for admission on 07/30/20 at 10:00am. -Resident #3's admission/move in date was 08/11/20 at 2:00pm. Refer to interview with the Business Office Manager (BOM) on 07/09/21 at 11:15am. Refer to interview with the Special Care Manager (SCM) on 07/08/21 at 10:45am. Refer to interview with an agency Registered nurse (RN) on 07/08/21 at 10:15am. Refer to interview with the Executive Director on 07/09/21 at 12:05pm. 2. Review of Resident #2's current FL2 dated 05/07/21 revealed diagnoses included, dementia, hypertension, hypothyroidism, general debility and convulsions/seizures. Review of Resident #2's Resident Register revealed the admission date was missing. Review of Resident #2's record revealed: -There was no admission checklist. -There was no initial assessment. -There was no TB tests or screening. Telephone interview with the Helth and Wellness Director (HWD) on 07/13/21 at 1:19pm revealed the was no TB information available in Resident #2's record, must be missplaced because Resident #2 could not be admitted to the facility without one.	D 433		

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D 433	Continued From page 229 Refer to interview with the Business Office Manager (BOM) on 07/09/21 at 11:15am. Refer to interview with the Special Care Manager (SCM) on 07/08/21 at 10:45am. Refer to interview with an agency Registered nurse (RN) on 07/08/21 at 10:15am. Refer to interview with the Executive Director on 07/09/21 at 12:05pm. 3. Review of Resident #4's current FL2 dated 04/09/21 revealed diagnoses included dementia with behavioral disturbances, history of falls and pain management. Review of Resident #4's record on 07/13/21 revealed: -Resident #4's Care Plan dated 10/01/20 was not signed by a physician. -There was no quarterly profile since admission. -There was no pre-admission assessment documented or an assessment 30 days after admission to the facility. Review of Resident #3's Resident Register revealed: -The date of admission was documented as 06/12/20. -The register was not signed or dated by the resident or the responsible family member. Refer to interview with the Business Office Manager (BOM) on 07/09/21 at 11:15am. Refer to interview with the Special Care Manager (SCM) on 07/08/21 at 10:45am. Refer to interview with an agency Registered	D 433		

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 433	Continued From page 230 nurse (RN) on 07/08/21 at 10:15am. Refer to interview with the Executive Director (ED) on 07/09/21 at 12:05pm. 4. Review of Resident #7's current FL2 dated 02/03/21 revealed: -Diagnoses included dementia, mood disorder, and dysuria (pain with urination). -She required personal care assistance with bathing, dressing, grooming, and toileting, and was incontinent of bladder. Review of Resident #7's Resident Register revealed an admission date of 02/11/21. Review of Resident #7's record on 07/09/21 revealed: -Resident #7's Care Plan was not documented in the record. -There was no quarterly profile since admission documented. -There was no significant change care plan documented after hospice admission. -There was no assessment documented pre-admission or 30 days after admission to the facility. Refer to interview with the Business Office Manager (BOM) on 07/09/21 at 11:15am. Refer to interview with the Special Care Manager (SCM) on 07/08/21 at 10:45am. Refer to interview with an agency Registered nurse (RN) on 07/08/21 at 10:15am. Refer to interview with the Executive Director (ED) on 07/09/21 at 12:05pm	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 433	Continued From page 231	D 433		

Interview with the Business Office Manager (BOM) on 07/09/21 at 11:15am revealed:
-When residents were admitted to the facility their current FL2 was part of their admission packet provided to the resident or their responsible party.
-She thought this was the responsibility of the Marketing team.
-A signed and dated FL2 was required prior to any resident being admitted to the facility.
-It was the responsibility of the clinical team to ensure the FL2, Care Plans and Assessments were current and in the resident's record.

Interview with the Special Care Manager (SCM) on 07/08/21 at 10:45am revealed:
-Agency nurses were hired a few weeks ago to complete audits of the residents' records to ensure they were complete, and the documents were up to date.
-She had recently been hired and was still in training.
-She had not audited the residents' records, and did not know what information they had or were missing.
-She thought it would be her responsibility to ensure residents' records were complete and up to date.

Interview with an agency Registered nurse (RN) on 07/08/21 at 10:15am revealed:
-She was contracted to complete resident record audits for missing and out of date documents.
-There were several resident records that needed updating.
-She was not sure who was responsible for auditing the records prior to her assignment at the facility.

Interview with the Executive Director (ED) on 07/09/21 at 12:05pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 433	Continued From page 232 -When the previous Health and Wellness Director left in May 2021, the facility contracted agency nurses to come in and audit residents' records. -She was informed by an agency RN completing resident record audits that there were documents missing and out of date in the residents' records. -The Health and Wellness Director would be responsible for auditing the resident's records ongoing.	D 433		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to notify the county Department of Social Services (DSS) of incidents for 4 of 7 sampled residents (#1, #4, #7 and #9) related to falls (#1, #7, #9) and elopements (#4). The findings are: 1. Review of Resident #9's FL2 dated 04/07/21 revealed diagnoses included, pulmonary embolism, syncope and collapse, essential hypertension and anxiety disorder. Review of the facility physician notification form dated 04/16/21 revealed:	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 451	Continued From page 233	D 451		

-Resident #9 was observed face down on her on the bathroom floor.
-Resident #9 complained of her back and neck hurting.
-Resident #9 was sent to the hospital.

Review of Resident #9's hospital discharge note dated 04/19/21 revealed:
-Resident #9 was admitted to the hospital on 04/16/21.
-Admitting diagnoses were physical debility with fall, neck and back pain, urinary tract infection, dehydration and acute toxic cephalopathy.

Review of Resident #9's record revealed there was no Incident and Accident report dated 04/16/21, related to the fall.

Interview with the social worker at the county Department of Social Services on 07/08/21 at 1:00pm revealed:
-She had not received and Incident and Accident report from the facility for Resident #9 dated 04/16/21.
-She was to receive an Incident and Accident report with all injuries that required more than first aid.
-She considered a fall with injuries required an Accident and Incident report to be filled out and a copy sent to her.

Refer to interview with the Executive Director on 07/07/21 at 4:57pm.

Refer to interview with the MA on 07/09/21 at 11:01am.

2. Review of Resident #4's FL2 dated 04/09/21 revealed diagnoses included dementia with behavioral disturbances, history of falls and pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 451	Continued From page 234	D 451		

management.
-Level of care was documented as Special Care Unit (SCU).

Review of the Resident #4's Incident/Accident report form dated 06/25/21 revealed:
-Resident #4 broke through the security fence surrounding the SCU and was found in the parking lot.
-The incident type was documented as an elopement.
-There was no documentation vitals signs were taken or the physician was notified.
-There was no documentation the responsible family member or the Adult Home Specialist was notified.
-There was no signature of the person completing the report.

Interview with the Adult Home Specialist (AHS) on 07/08/21 at 1:00pm revealed she had not received Resident #4's Incident/ Accident report dated 06/25/21.

3. Review of Resident #7's FL2 dated 02/09/21 revealed diagnoses included dementia with behavioral disturbances, anxiety and mood disorder.

Review of the facility's Communication Log dated 05/24/21 revealed Resident #7 fell and was transported to the hospital on 05/24/21.

Review of Resident #7's record revealed:
-There was no discharge summary from the hospital visit on 05/24/21.
-There was no further documentation in the Communication Log regarding the fall or interventions in place.
-There was no Incident/Accident report for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 451	Continued From page 235 Resident #7's hospital visit dated 05/24/21. Interview with the AHS on 07/08/21 at 1:00pm revealed: -She had not received Resident #7's Incident/ Accident report dated 05/24/21. -She was to receive an Incident /Accident report with all injuries that required more than first aid. -A fall with injuries required an Incident/Accident report to be filled out and a copy sent to her. Refer to interview with the Executive Director on 07/07/21 at 4:57pm. Refer to interview with the MA on 07/09/21 at 11:01am. 4. Review of Resident #1's most recent FL2 dated 05/20/21 revealed diagnoses included hypertension, dementia, anxiety, pain and atrial fibrillation. Review of Resident #1's progress note dated 04/26/21 at 4:21pm revealed: -Resident #1 was found on the bathroom floor. -Emergency Medical Services (EMS) was called and Resident #1 was sent to the hospital. Review of Resident #1's incident report dated 04/26/21 at 3:40pm revealed: -Resident #1 had an unwitnessed fall and was found on the bathroom floor. -Resident #1 complained of knee pain. Review of Resident #1's Emergency Department (ED) Discharge Summary dated 04/27/21 revealed: -Resident #1 presented to the ED following a fall at the facility. -Resident #1 did not sustain any fractures and	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 451	Continued From page 236 was discharged back to the facility. Interview with a social worker at the county Department of Social Services (DSS) on 07/08/21 at 1:00pm revealed: -She had not received an Incident and Accident report from the facility for Resident #1 dated 04/26/21. -She was supposed to receive an Incident and Accident report for all incidents that required a resident to be transported to the emergency room. Refer to interview with the Executive Director on 07/07/21 at 4:57pm. Refer to interview with a MA on on 07/09/21 at 11:01am. _____ Interview with the Executive Director (ED) on 07/07/21 at 4:57pm revealed: -The lead MA on each shift was responsible for completing the Incident/Accident reports and sending them to the Health and Wellness Director (HWD). -The HWD was responsible for any corrections to the form, notification to the physician and responsible family member. -The Corporate Contact instructed her to follow the directives of the Adult Home Specialist (AHS). -The AHS did not instruct her to send them to the AHS. Interview with a medication aide (MA) on 07/09/21 at 11:01am revealed: -The lead MA would fill out the Incident/Accident reports and send them to the Health and Wellness Director (HWD). -The HWD was responsible for contacting the physician and the responsible family member.	D 451		

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 451	Continued From page 237 -She was not sure where the reports were filed when completed.	D 451		
D 462	10A NCAC 13F .1305 Special Care Unit Policies And Procedures 10A NCAC 13F .1305 Special Care Unit Polices And Procedures The facility shall assure that special care unit policies and procedures are established, implemented by staff and available for review within the facility. In addition to all applicable policies and procedures for adult care homes, there shall be policies and procedures that address the following: (1) the philosophy of the special care unit which includes a statement of mission and objectives regarding the specific population to be served by the unit which shall address, but not be limited to, the following: (a) safe, secure, familiar and consistent environment that promotes mobility and minimal use of physical restraints or psychotropic medications; (b) a structured but flexible lifestyle through a well developed program of care which includes activities appropriate for each resident's abilities; (c) individualized care plans that stress the maintenance of residents' abilities and promote the highest possible level of physical and mental functioning; and (d) methods of behavior management which preserve dignity through design of the physical environment, physical exercise, social activity, appropriate medication administration, proper nutrition and health maintenance; (2) the process and criteria for admission to and discharge from the unit;	D 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 462	Continued From page 238 (3) a description of the special care services offered in the unit; (4) resident assessment and care planning, including opportunity for family involvement in care planning, and the implementation of the care plan, including responding to changes in the resident's condition; (5) safety measures addressing dementia specific dangers such as wandering, ingestion, falls and aggressive behavior; (6) staffing in the unit; (7) staff training based on the special care needs of the residents; (8) physical environment and design features that address the needs of the residents; (9) activity plans based on personal preferences and needs of the residents; (10)opportunity for involvement of families in resident care and the availability of family support programs; and (11)additional costs and fees for the special care provided. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure hazardous products were stored in a locked area resulting in a hazardous aerosol, and personal care items being unattended and accessible to residents who resided in the Special Care Unit (SCU). The findings are: Observation of residents' room during the tour of the SCU on 07/07/21 between 8:00am and 2:00pm revealed: -Room #110 and #112 were unlocked and easily assessable to the hallway leading to common	D 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 462	Continued From page 239 living and dining room. -In the entrance to Room #110, in an unlocked cabinet on the wall over the vanity there was a large bottle of alcohol-based mouthwash, shampoo, and body wash. -In the entrance to Room #112, in an unlocked cabinet on the wall over the vanity there was a bottle of perfume, aerosol hairspray, moisturizing lotion, two electric curling irons. -Residents were observed in these rooms and walking past them in the hallway stopping, opening the doors leading into these rooms, and entering the rooms. Observation of residents' room of the SCU on 07/08/21 between 8:00am and 2:00pm revealed: -Room #110 and #112 were unlocked and easily assessable to the hallway leading to common living and dining room. -In the entrance to Room #110, in an unlocked cabinet on the wall over the vanity there was a large bottle of alcohol-based mouthwash, shampoo, and body wash. -In the entrance to Room #112, in an unlocked cabinet on the wall over the vanity there was a bottle of perfume, aerosol hairspray, moisturizing lotion, two electric curling irons. -Residents were observed in these rooms and walking past them in the hallway stopping, opening the doors leading into these rooms, and entering the rooms. Observation of residents' room during the tour of the SCU on 07/13/21 between 8:00am and 2:00pm revealed: -Room #110 and #112 were unlocked and easily assessable to the hallway leading to common living and dining room. -In the entrance to Room #110, in an unlocked cabinet on the wall over the vanity there was a	D 462		

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D 462	Continued From page 240	D 462		

large bottle of alcohol-based mouthwash, shampoo, and body wash.
-In the entrance to Room #112, in an unlocked cabinet on the wall over the vanity there was a bottle of perfume, aerosol hairspray, moisturizing lotion, two electric curling irons.
-Residents were observed in these rooms and walking past them in the hallway stopping, opening the doors leading into these rooms, and entering the rooms.

Review of the Material Safety Data Sheets for the personal care products and product labeling left unsecured on 07/07/21, 07/08/21 and 07/13/21 revealed:
-An aerosol hairspray could cause a chemical burn to the skin, eyes, or any mucosa membrane of the body.
-Ingestion of an alcohol-based mouthwash or perfume over a period could led to alcohol toxicity or altered mental status.
-The shampoo, perfume, and lotions could all cause nausea, vomiting, diarrhea, eye and gastrointestinal injury if ingested.
-All these items were labeled with warning labels.
-The labels recommended that all these items be kept out of reach to prevent these injuries.

Interview with a personal care aide (PCA) on 07/07/21 at 9:20am revealed:
-The residents' family members provided all the residents' personal care items.
-The residents' personal care items were supposed to be locked in the cabinets above the vanity in their rooms.
-She did not have a key to the cabinet to open it and lock it, if she needed to asked MA for a key that fit all the residents' cabinets.
-The cabinet was left open after somebody removed items from it or put them back inside.

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 462	Continued From page 241 Interview with a medication aide (MA) on 07/08/21 at 10:00am revealed: -She did not realize the cabinets were left unlocked until it was brought to her attention. -All the staff (PCAs and MAs) were expected to use the key to open the cabinets and lock them afterwards. -There were agency staff that worked with the residents that must be leaving the cabinets unlocked. -There were two keys on the SCU for the cabinets one for the PCAs and one the MA. -The keys were kept with the shift keys on a key ring in their pocket with other unit keys. -She did not go behind the PCAs to make sure the cabinets were locked. -All staff on the SCU were responsible for ensuring the cabinet doors were kept locked. Interview with the Memory Care Manager (MCM) on 07/13/21 at 10:30am revealed: -She did not routinely check the residents' cabinets to make sure they were locked. -The staff was reminded during huddles held the last two days this week to make sure all the residents' cabinets were locked every shift. Interview with the Executive Director on 07/12/21 at 4:45pm revealed: -The staff on the SCU knew to keep the residents' personal care items locked in the cabinets. -There was signage posted as reminders to the hazards of the personal care items. -There were two keys available to make sure the cabinets were kept locked. -She depended on all of the staff on the SCU to keep hazardous items locked up to prevent the residents from injury.	D 462		

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D 463	Continued From page 242	D 463		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled residents residing in the Special Care Unit (SCU) had a pre-admission screening (Residents #2, #4 and #7) and 3 out of 3 sampled residents did not have a disclosure statement (Residents #3, #4 and #7). The findings are: 1. Review of Resident #2's current FL2 dated 05/07/21 revealed:	D 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 463	Continued From page 243 -Diagnoses included, dementia, hypertension, hypothyroidism, general debility and convulsions/seizures. -The level of care was documented as, other SCU. -Resident #2 was intermittently disoriented. a. Review of Resident #2's record revealed there was no pre-admission screening for the resident to evaluate the appropriateness of the resident's placement in the SCU. Telephone interview with Resident #2's Power of Attorney (POA) member on 07/08/21 at 3:23pm revealed she could not recall if the pre-admission screening was performed before Resident #2 was admitted to the SCU. Refer to the interview with the Business Office Manager on 07/13/21 at 9:55am. Refer to the interview with the Executive Director on 07/09/21 at 12:05pm. b. Review of Resident #2's record revealed there was no documentation of a disclosure statement regarding policies and procedures in the SCU was provided that was signed by the POA. Telephone interview with Resident #2's responsible family member on 07/08/21 at 3:23pm revealed she signed a copy of the SCU disclosure statement before Resident #2 was admitted to the SCU. Refer to interview with the Business Office Manager on 07/13/21 at 9:55am. Refer to interview with the Executive Director on 07/09/21 at 12:05pm.	D 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 463	Continued From page 244 2. Review of Resident #4's current FL2 dated 05/07/21 revealed: -Diagnoses included included dementia with behavioral disturbances, history of falls and pain management. -The level of care was documented as the Special Care Unit (SCU). Review of Resident #4's record revealed: -There was no documentation a SCU pre-admission screening was completed for the resident to evaluate the appropriateness of the resident's placement in the SCU. -There was no documentation of a disclosure statement signed by the responsible family member. Refer to the interview with the Business Office Manager on 07/13/21 at 9:55am. Refer to the interview with the Executive Director on 07/09/21 at 12:05pm 3. Review of Resident #7's current FL2 dated 02/09/21 revealed: -Diagnoses included dementia with behavioral symptoms, anxiety and mood disorder -The level of care was documented as SCU. -Resident #7 was constantly disoriented. Review of Resident #7's record revealed: -There was no documentation a SCU pre-admission screening for the resident to evaluate the appropriateness of the resident's placement in the SCU. -There was no documentation of an assessment completed 30 days after admission. -There was no documentation of a disclosure statement signed by the responsible family	D 463		

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

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D 463	Continued From page 245 member. Refer to the interview with the Business Office Manager on 07/13/21 at 9:55am. Refer to the interview with the Executive Director on 07/09/21 at 12:05pm Review of Resident #3's current FL2 with no date revealed diagnoses included Alzheimer's disease, nocturia related to benign prostate hyperplasia, diabetes, and bilateral lower extremity edema. Review of Resident #3's record revealed there was no documentation that a disclosure regarding policies and procedures in the SCU was provided to and signed by the family members. Telephone interview with Resident #3's responsible family member on 07/07/21 at 3:41pm revealed she could not recall if disclosure information or a document with the information was presented to her regarding Resident #3's admission to the SCU. Refer to the interview with the Business Office Manager on 07/13/21 at 9:55am. Refer to the interview with the Executive Director on 07/09/21 at 12:05pm. _____ Interview with the Business Office Manager on 07/13/21 at 9:55am revealed: -The Marketing Manager should present the SCU disclosure statement to the responsible family member to review and sign. -The disclosure statement should them be filed in the resident's record. Interview with the Executive Director on 07/09/21	D 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 463	Continued From page 246 at 12:05pm revealed: -She was not sure who was responsible for presenting the SCU disclosure statement to the responsible family member. -She though the signed disclosure statement was kept in the business office. -The clinical team was responsible for resident assessments and care plans. -She thought the Health and Wellness Director (HWD) completed the quarterly reports for the SCU residents.	D 463		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on record reviews and interviews, the	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 464	Continued From page 247	D 464		

facility failed to ensure 2 of 3 sampled residents, (Residents #3, and #4), residing in the Special Care Unit (SCU) had a quarterly resident profile completed.

The findings are:

1. Review of Resident #4"s current FL2 dated 04/09/21 revealed:
-Diagnoses included dementia with behavioral disturbance, history of falls and pain management.
-Special Care Unit (SCU) was documented as the recommended level of care.
-Resident #4 was intermittently disoriented.

Review of Resident #4's Resident Register revealed an admission date of 06/12/20 .

Review of Resident #4's Care Plan revealed it had been completed on 10/01/20.

Review of Resident #4's record revealed there was no quarterly profile completed for Resident #4.

Refer to the interview with the Health and Wellness Director (HWD) on 07/12/21 at 2:20pm.

Refer to the interview with the Executive Director (ED) on 07/09/21 at 12:05pm.

2. Review of Resident #3's current FL2 (no date) revealed diagnoses included Alzheimer's disease, nocturia related to benign prostate hyperplasia, diabetes, and bilateral lower extremity edema.

Review of Resident #3's Resident Register revealed there no date of admission.

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 464	Continued From page 248	D 464		

Review of Resident #3's new admission checklist revealed:
-Resident #3 received an assessment for admission on 07/30/20 at 10:00am.
-Resident #3's admission/move in date was 08/11/20 at 2:00pm.

Review of Resident #3's care plan revealed it had been completed on 09/03/20.

Review of Resident #3's record revealed there was no resident profile completed for Resident #3.

Refer to interview with the Health and Wellness Director on 07/12/21 at 2:20pm.

Refer to the interview with the Executive Director on 07/12/21 at 4:45pm.

_____

Interview with the Health and Wellness Director on 07/12/21 at 2:20pm revealed:
-She had been working with the Resident Care Director (RCD) and the SCM to get processes and procedures in place for the newly hired HWD.
-She was not aware of the quarterly profile for the memory care residents.
-She did not know the previous HWD had completed quarterly profiles on the Special Care residents.
-The quarterly profiles for the residents on the SCU would be implemented with the newly hired HWD and coordinated with the SCM.

Interview with the Executive Director on 07/09/21 at 12:05pm revealed:
-The Health and Wellness Director (HWD) or Special Care Manager (SCM) were responsible for residents' quarterly profiles on the SCU.
-She thought the previous HWD completed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 464	Continued From page 249 quarterly care plans for the SCU residents.	D 464		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that 3 of 3 sampled staff (Staff A,	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 468	Continued From page 250 B and C) completed six hours of dementia specific training within their first week of working in the Special Care Unit (SCU). The findings are: 1. Review of Staff A's, personnel record revealed: -There was no documentation of Special Care Unit (SCU) training completed for Staff A. -There was no date of hire for Staff A. -She worked as a medication aide (MA) on the SCU. Interview with Staff A on 07/07/21 at 9:15am revealed: -She was hired over a year ago and worked as a MA in the SCU. -She thought she completed all her assigned SCU training but was not sure. Refer to the interview with the Business Office Manager on 07/09/21 at 11:15 am Refer to interview with the Executive Director on 07/09/21 at 12:05pm. 2. Review of Staff B's, personnel record revealed: -There was no documentation of Special Care Unit (SCU) training completed for Staff B. -There was no date of hire for Staff B. -She worked as a personal care aide (PCA on the SCU. Interview with Staff B on 07/07/21 at 9:15am revealed: -She was employed by a temporary staffing agency as a PCA. -She worked in the SCU as well as the assisted living unit in the past two weeks. -She was not asked to provide documentation of	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 468	Continued From page 251 previous SCU training to the facility. Telephone interview with a representative from the temporary staffing agency on 07/12/21 at 9:45am revealed they did not provide SCU training. Refer to the interview with the Business Office Manager on 07/09/21 at 11:15 am Refer to interview with the Executive Director on 07/09/21 at 12:05pm. 3. Review of Staff C's, personnel record revealed: -There was no documentation of Special Care Unit (SCU) training completed for Staff C. -There was no date of hire for Staff C. Interview with Staff C on 07/08/21 at 9:00am revealed: -She was employed by a temporary staffing agency as a PCA. -She was assigned to SCU but worked with the assisted living residents as well. -She was not asked to provide documentation of previous SCU training to the facility. Interview with a representative from a second temporary staffing agency on 07/12/21 at 9:00am revealed they were not requested to provide SCU training prior to providing personal care staff to work at the facility. Refer to the interview with the Business Office Manager on 07/09/21 at 11:15 am Refer to interview with the Executive Director on 07/09/21 at 12:05pm. _____ Interview with Business Office Manager on	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 468	Continued From page 252 07/09/21 at 11:15am revealed: -It was her responsibility to maintain the personnel records. -She had not audited the personnel records since she started in her role the middle of June 2021. -She did not request documentation of SCU training for the agency staff. -She thought the staffing agencies completed the SCU training and she did not need a copy of their training hours. Interview with Executive Director on 07/09/21 at 12:05pm revealed: -The BOM was responsible for maintaining the staff records. -She did not know the staff working in the SCU did not have any documentation of SCU training. -The staffing agency was responsible for the orientation and onboarding of their staff. -She had not audited the staff records since the new BOM started last month to determine if all SCU staff had their required dementia training.	D 468		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to building service equipment,	D912		

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D912	Continued From page 253 health care, and medication aides; training and competencies. The findings are: 1. Based on observations and interviews the facility failed to ensure hot water temperatures at 10 of 10 fixtures accessible to residents (sinks in rooms 101, 104, 113, 221, 204, 224, 228, and 304) were maintained between 100 degrees Fahrenheit (F) and 116 degrees F. [Refer to Tag 0113 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to implement an order for 4 of 7 residents, related to the application and removal of thromboembolic deterrent hose (Resident #3 and #9), orders for weekly blood pressure checks (Resident #7) and a diet change (#20). [Refer to Tag 0276 10A NCAC 13F .0902 (c3-4) Health Care (Type B Violation)]. 3. Based on interviews and record reviews, the facility failed to ensure the completion of 5, 10 or 15-hour medication aide training, medication aide exam, and medication administration clinical skills validation for 2 of 4 sampled medication aides (Staff A and D). [Refer to Tag 0935, 131D4.5(B) Ach Medication Aides; Training and Competencies (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D914	Continued From page 254 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all residents were free from neglect related to personal care, supervision, health care, resident rights, and medication administration. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance for 4 of 5 residents (Residents #3, #4, #7, and #9) including assistance with showers and linen changes weekly and as needed due to an increased level of care (Resident #9), assistance with a walker and gripper socks for safety with ambulation (Resident #4), assistance with oral care and repositioning a bed bound resident (Resident #7), and assistance with toileting, showers and dressing (Resident #3). [Refer to Tag 0269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to provide supervision for 4 of 6 sampled residents related to residents with elopement incidents (#3, #4, #5) and a resident with an order for the Special Care Unit (SCU) who required increased supervision to prevent an elopement (#6). [Refer to Tag 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 3. Based on observations, interviews, and resident reviews, the facility failed to meet the health care needs for 5 of 7 residents (#1,#2, #5, #13 & #18) in a regard to a resident complaining of respiratory symptoms and a referral to the	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D914	Continued From page 255	D914		

hospital after a fall, (#2), a resident with a referral to a cardiologist (#5), a resident with ongoing mouth pain (#1), a resident missing an order for a blood thinner (#18), and an order to change the frequency of a laxative (#13). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].

4. Based on observations, record reviews and interviews, the facility failed to ensure residents were treated with respect, consideration, and dignity related to a resident who was continent was made to wear incontinent briefs and go to bed early because staff refused to assist with her personal care needs (#13); a resident who resided in the Assisted Living (AL) with an order to be admitted to the Special Care Unit (SCU) and remained on the AL with behaviors (#6); a resident on the AL was taken to the SCU during the day and returned to the AL during the night which worsened behaviors (#5, #6); staff refusing to assist a resident who required assistance with transfers and/or causing pain with transfers resulted in the resident rarely getting out of bed for three months (#9); a delay in call bell response with residents who required assistance (#12); and residents in the AL having to contend with dementia behaviors that were not resolved by staff; two resident with room changes without consent to move (#1, #6). [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)].

5. Based on observations, interviews and record reviews, the facility failed to ensure 2 of 4 residents observed during the medication pass received their medications as ordered by the primary care physician (PCP) including a medication used to treat depression, a medication used to prevent strokes (#14) and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D914	Continued From page 256 medication used to lower cholesterol (#15). The facility failed to administer medications as ordered for 12 of 14 sampled residents related to two medications used to treat dementia (Resident #1), an antiseizure medication (Resident #2) and an antibiotic (Resident #3), a medication used to treat osteoporosis (Resident #6), a medication for depression (Resident #7 and #16), a bronchodilator used to relax muscles in the airways and increase air flow to the lungs (Resident #8), a medication used to treat glaucoma (Resident #11), two medications to control fluid buildup and a medication for nerve pain (Resident #12), medications used to treat high blood pressure (Resident #13, #17 and #18), medications used to treat and prevent blood clots (Resident #16, and #18), a medication used to treat atrial fibrillation (Resident #16), a medication used to treat underactive thyroid gland and two dietary supplements (Resident #16). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)]. 6. Based on observations, interviews, and record reviews, the Administrator failed to ensure the overall management, operations, policies and procedures of the facility were implemented, maintained, and in substantial compliance with the rules and statutes to meet and maintain rules related to personal care and supervision, medication administration, other requirements, health care, resident rights, and adult care medication aide training. [Refer to Tag 980 10A NCAC 13F 131D-25 Implementation (Type A1 Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D935	Continued From page 257 G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in	D935		

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D935	Continued From page 258 accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure the completion of 5, 10 or 15-hour medication aide training, medication aide exam, and medication administration clinical skills validation for 2 of 4 sampled medication aides (Staff A and D). The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A did not have a staff record. -Staff A did not have documentation of medication training. -There was no documentation Staff A completed a Medication Administration Clinical Skills Validation Checklist. -There was no documentation Staff A successfully completed a Medication Administration Exam. Review of electronic medication administration record (eMAR) revealed Staff A administered medications on 07/07/21 and 07/08/21. Observation of Staff A on 07/07/21, 07/08/21 and 07/13/21 during the medication pass revealed she administered medications to the residents. Interview with Staff A on 07/07/21 at 9:15am revealed: -She was hired to work at the facility over a year ago but did not know her exact date of hire. -She completed her MA training, exam, and medication aide skills check off for medication administration with a facility contracted agency	D935		

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D935	Continued From page 259	D935		

nurse when she started work at the facility.
-She administered all the medications to the residents in the Special Care Unit (SCU) during first shift on the days she worked at the facility.

Interview with the Business Office Manager (BOM) on 07/09/21 at 11:15am revealed:
-She was hired three weeks ago and the previous BOM did not have a staff folder for Staff A.
-She had not had time ask Staff A about her MA training hours.
-It was her responsibility to maintain the staff records.

Interview with the Executive Director (ED) on 07/09/21 at 12:05pm revealed:
-She expected the BOM to maintain the staff records.
-She did not know Staff A did not have the required MA training documentation, MA exam or MA skills validation check off list in her staff record.
-She had not audited staff records since the previous BOM quit last month.

2. Review of Staff D's, medication aide (MA), personnel record revealed:
-Staff D did not have a staff record.
-Staff D did not have documentation of medication training.
-There was no documentation Staff D completed a Medication Administration Clinical Skills Validation Checklist.
-There was no documentation Staff D successfully completed a Medication Administration Exam.

Review of documentation on the electronic medication administration record (eMAR) revealed Staff E administered medications from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D935	Continued From page 260 06/18/21-06/23/21. Attempted telephone interview with Staff E on 07/12/21 at 9:00am was unsuccessful. Telephone interview with a representative from the temporary staffing agency on 07/12/21 at 1:09pm revealed: -The agency did not automatically provide the facility with MA training hours, MA exam date or MA clinical skills verification. -In the past, Administrators requested copies of the documents from the agency. Interview with the Business Office Manager (BOM) on 07/09/21 at 11:15am revealed: -She was hired three weeks ago and had not received any copies of agency staff MA training hours. -She did not know that the facility was required to verify the staff the agencies were providing had documentation of MA training, MA exam and MA clinical skills validation check off lists. Interview with the Executive Director (ED) on 07/09/21 at 12:05pm revealed: -The facility contracted with three different staffing agencies. -Two of the staffing agencies were contracted prior to her coming to the facility. -She contracted with the third agency that told her they maintained staff credentials through an application on their cellphones. -She had a verbal agreement with the staffing agency for all MAs to have the required MA training but did not request a hard copy of the documentation. -She expected the BOM to maintain the staff records. -She had not audited staff records since the	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D935	Continued From page 261 previous BOM quit last month. Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration. _____ The facility the facility failed to ensure the completion of 5, 10, or 15-hour medication aide training, medication aide exam, and medication administration clinical skills validation for 2 of 4 sampled staff prior to administering medications to the residents placing the resident at risk for medication administration errors. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/09/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 27, 2021.	D935		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the overall management, operations, policies and	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 262	D980		

procedures of the facility were implemented, maintained, and in substantial compliance with the rules and statutes to meet and maintain rules related to personal care and supervision, medication administration, other requirements, health care, resident rights, and adult care medication aide training.

Interview with the Business Office Manager (BOM) on 07/07/21 at 11:10am revealed:
-She was currently in the role as the BOM at the facility while the Executive Director (ED) was hiring for that position.
-She had her Administrator's license and would be leaving in a few weeks for a new position.
-She had agreed to have her license displayed while she was in the facility and the ED was waiting to take her Administrator's test in August 2021.
-The ED was responsible for the day to day operations at the facility and she requested all questions and concerns to be directed to the ED.

Interview with the Executive Director (ED) on 07/07/21 at 10:35am and 07/09/21 at 4:46pm revealed:
-She started as the ED in March 2021.
-She had an Administrator license, but it expired.
-She was scheduled to take her Administrator exam on 08/13/21.
-The BOM was a licensed Administrator and had her license on the wall by the reception desk until she took her exam.
-When she started in March 2021 the Health and Wellness Director (HWD) was failing to fulfill the responsibilities of her role.
-The HWD quit in the middle of May 2021.
-The HWD was responsible for overseeing all the clinical services provided to the residents.
-Since she started in March the Resident Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 263 Director, Resident Care Coordinator, Special Care Manager, and the BOM were all newly hired or new in their roles. -She contacted the corporate office and the Regional Quality Assurance Nurse came to assist by taking on the role of the HWD the end of May 2021. -She contacted staffing agencies to provide nurses to complete audits of the residents' records. -She contacted staffing agencies to provide personal care aides (PCA) and medication aides (MA) and depended on the staffing agencies to ensure the staff they provided had the appropriate staff qualifications. -She had a hard time finding time to provide an adequate amount of time to make sure staff were doing their jobs. Interview with an agency Registered Nurse (RN) on 07/08/21 at 9:40am revealed: -She was contracted by the facility to perform audits of the residents' records and started two weeks ago (06/23/21). -When she discovered issues with residents' records, she was instructed by the HWD to place them in a folder for review and follow up with residents' PCP or the pharmacy. -She never met the ED. Interview with an agency personal care aide (PCA) on 07/07/21 at 10:20am revealed: -She was not provided care plans or activity of daily living (ADL) listings for the residents on the hallway for her work assignment. -She did not know who she would report any problems she had getting enough supplies like gloves to provide personal care for the residents. -She was not told the names of residents who required increased supervision, so she checked	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D980	Continued From page 264	D980		

on the all the residents at least every two hours.
Interview with the SCU MA on 07/09/21 at 10:00am revealed:
-Sometimes residents who required more frequent supervision than every two hours were identified, and their names were written on the white board in the medication room.
-There was a resident that eloped from the facility and found on the other side of the 5-lane road in front of the facility twice.
-The resident's name who eloped was not written on the white board and she was not told to increase supervision for this resident.

Interview with a personal care aide (PCA) on 07/08/21 at 8:45am revealed:
-The hot water temperature was 120 degrees F. when the Maintence Director (MD) checked it after she informed him about it.
-She was told the hot water was "with in regulations" so she never said anything again.
-She did not say anything more about the hot water feeling hot to her because the MD was responsible for knowing the safe hot water temperature.

Telephone interview with the MD on 07/12/21 at 2:15pm revealed:
-He had been the MD since January 2021.
-He received his training from another MD at a sister facility and the Regional MD for one day in January 2021.
-It was his understanding from the training he received, hot water temperatures up to 135 were acceptable and within the state mandated regulations.
-He did not find out until 07/07/21, after it was brought to his attention by the surveyors and the local Environmental Health representative that, hot water temperatures above 116 were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 265	D980		

acceptable and against regulations.
-He was responsible for completing hot water checks on a weekly basis by taking hot water temperatures in 11 resident rooms located in the Assisted Living (AL) and the SCU.
-Since January 2021 he had many temperatures documented in the log that were greater than 116 degrees F and did not attempt to correct the hot water temperatures.
-He entered the water temperatures electronically and reported them verbally to the ED weekly.
-Prior to 07/07/21, if the hot water temperature were higher that 135 degrees F, he would notify the staff on the affected halls located on the AL side.
-He would instruct the staff to put up "caution signs" in each AL room affected.
-Prior to 07/07/21, if the hot water temperature were higher that 135 degrees F, he would notify the staff in the SCU and cut off the affected rooms individual water until it was fixed and registered a hot water temperature less that 135 degrees F and then turn the water back on.
-If he was unable to regulate the hot water to the regulatory temperature then he would contact the contracted company to come out and fix the issue.

Interview with the Executive Director (ED) on 07/08/21 at 3:00pm revealed:
-The maintenance director (MD) was responsible for documenting the weekly water temperatures in a binder that should be at the front desk.
-He should be taking a random water temperature reading throughout the community daily.
-She received a monthly report from the MD on any water temperature readings that were not within regulatory range.
-She would have to review the regulatory water

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 266 temperature range because she was not sure at the time of the interview what the acceptable range was. Interview with the HWD on 07/12/21 at 3:15pm revealed : -Hospice was providing oversite for the care of a resident since the end of May. -The resident had a decline in health the past week and was in the bed more frequently. -It was not reported to her the resident had skin breakdown on her lower back and buttocks. -She had not instructed the staff to reposition residents who were bed bound every 2 hours. -She had not instructed staff to offload resident's weight when sitting in a wheelchair for long periods of time. -She thought hospice may have given the staff and the SCM some instructions regarding the care of their residents. Interview with the ED on 07/09/21 at 12:05pm revealed: -The clinical team was responsible for resident assessments and Care Plans. -She thought the Health and Wellness Director (HWD) completed the quarterly reports for the SCU residents. -She was not sure where the quarterly reports for the SCU residents were kept if not in their record. Interview with the ED on 07/09/21 at 12:05pm revealed: -She was not sure who was responsible for presenting the disclosure document to the responsible family member. -She was not sure when it was presented to the responsible family member or guardian. -She thought the signed disclosure statement was kept in the business office.	D980		

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 267 Interview with a personal care aide (PCA) on 07/07/21 at 9:46am revealed: -She was from an agency and worked at the facility for a month and a half. -A resident did not receive showers because she was too hard to get up and resisted care. -It took two staff to get her up but when staff attempted to deliver care she was resistant because she was fearful of falling. -She was not sure if the resident received bed baths or not. -There was no where to document the care provided. -She informed the medication aide (MA), Resident Care Director (RCD), Health and Wellness Director (HWD) and the Executive Director (ED) during the first week she worked here about how hard it was to get Resident #9 up and was told by all 4 staff, "that's how she is" and there was nothing they could do about it. Interview with the Resident Care Director (RCD) on 07/12/21 at 2:00pm revealed: -She was responsible for following up with new orders to ensure they were accurately placed in the eMAR system by the pharmacy. -She felt the medication order system needed work because medications were often not available for administration. -There was a system put into place at the end of May 2021 in which an order was flagged in the resident's record until it was completed, and the medication was available, but staff did not follow the process. -She tried to follow up on medication issues, such as insurance denials and medications not available, but there was no system. -She relied on her memory to follow up on	D980		

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	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D980	Continued From page 268	D980		

medication concerns.
-MAs were responsible to reorder resident medications when there were seven doses remaining.
-The third shift MAs were responsible for medication cart audits, but she did not know what the process was.
-There was no one reviewing the eMARs for medications not administered.

Interview with a Primary Care Provider (PCP) at the facility on 07/12/21 at 10:53am revealed:
-She was not aware several medications for her residents were not being administered as ordered.
-She expected the facility to notify her or her office of any refills needed and if a resident was not receiving medications as ordered.
-There was poor communication between facility staff and providers.

Non-compliance was identified at violation levels in the following areas:

1. Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance for 4 of 5 residents (Residents #3, #4, #7, and #9) including assistance with showers and linen changes weekly and as needed due to an increased level of care (Resident #9), assistance with a walker and gripper socks for safety with ambulation (Resident #4), assistance with oral care and repositioning a bed bound resident (Resident #7), and assistance with toileting, showers and dressing (Resident #3). [Refer to Tag 0269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation)].

2. Based on observations, interviews and record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 269	D980		

reviews, the facility failed to provide supervision for 4 of 6 sampled residents related to residents with elopement incidents (#3, #4, #5) and a resident with an order for the Special Care Unit (SCU) who required increased supervision to prevent an elopement (#6). [Refer to Tag 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].

3. Based on observations, interviews, and resident reviews, the facility failed to meet the health care needs for 5 of 7 residents (#1,#2, #5, #13 & #18) in a regard to a resident complaining of respiratory symptoms and a referral to the hospital after a fall, (#2), a resident with a referral to a cardiologist (#5), a resident with ongoing mouth pain (#1), a resident missing an order for a blood thinner (#18), and an order to change the frequency of a laxative (#13). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].

4. Based on observations, record reviews and interviews, the facility failed to ensure residents were treated with respect, consideration, and dignity related to a resident who was continent was made to wear incontinent briefs and go to bed early because staff refused to assist with her personal care needs (#13); a resident who resided in the Assisted Living (AL) with an order to be admitted to the Special Care Unit (SCU) and remained on the AL with behaviors (#6); a resident on the AL was taken to the SCU during the day and returned to the AL during the night which worsened behaviors (#5, #6); staff refusing to assist a resident who required assistance with transfers and/or causing pain with transfers resulted in the resident rarely getting out of bed for three months (#9); a delay in call bell response with residents who required assistance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 270 (#12); and residents in the AL having to contend with dementia behaviors that were not resolved by staff; two resident with room changes without consent to move (#1, #6). [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to ensure 2 of 4 residents observed during the medication pass received their medications as ordered by the primary care physician (PCP) including a medication used to treat depression, a medication used to prevent strokes (#14) and a medication used to lower cholesterol (#15). The facility failed to administer medications as ordered for 12 of 14 sampled residents related to two medications used to treat dementia (Resident #1), an antiseizure medication (Resident #2) and an antibiotic (Resident #3), a medication used to treat osteoporosis (Resident #6), a medication for depression (Resident #7 and #16), a bronchodilator used to relax muscles in the airways and increase air flow to the lungs (Resident #8), a medication used to treat glaucoma (Resident #11), two medications to control fluid buildup and a medication for nerve pain (Resident #12), medications used to treat high blood pressure (Resident #13, #17 and #18), medications used to treat and prevent blood clots (Resident #16, and #18), a medication used to treat atrial fibrillation (Resident #16), a medication used to treat underactive thyroid gland and two dietary supplements (Resident #16). [Refer to Tag 0358 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)]. 6. Based on observations and interviews the facility failed to ensure hot water temperatures at 10 of 10 fixtures accessible to residents (sinks in	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 271 rooms 101, 104, 113, 221, 204, 224, 228, and 304) were maintained between 100 degrees Fahrenheit (F) and 116 degrees F. [Refer to Tag 0113 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)]. 7. Based on observations, interviews and record reviews, the facility failed to implement an order for 4 of 7 residents, related to the application and removal of thromboembolic deterrent hose (Resident #3 and #9), orders for weekly blood pressure checks (Resident #7) and a diet change (#20). [Refer to Tag 0276 10A NCAC 13F .0902 (c3-4) Health Care (Type B Violation)]. 8. Based on interviews and record reviews, the facility failed to ensure the completion of 5, 10 or 15-hour medication aide training, medication aide exam, and medication administration clinical skills validation for 2 of 4 sampled medication aides (Staff A and D). [Refer to Tag 0935, 131D4.5(B) Ach Medication Aides; Training and Competencies (Type B Violation)]. _____ The Administrator failed to ensure overall management and operations of the facility which resulted in hot water temperatures between 118 degrees F and 124 degrees F in the AL and the SCU. Hot water temperatures at 120 degrees could result in a second degree burn in 2 minutes and a third degree burn in 5 minutes. Hot water temperatures above 124 degrees F could result in a second degree burn within 2 minutes and a third degree burn within 3 minutes; The facility failed to provide personal care assistance for a resident with poor oral hygiene resulting in a thick, black build up around her remaining 8 teeth, leaving the remaining teeth loose and causing her pain and not providing proper incontinence care or repositioning the resident	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 272	D980		

which resulted in discoloration and broken areas of the skin (Resident #7); a dementia resident with a recent injury from a fall who required a walker and proper foot coverings for safety with ambulation (Resident #4); a resident who required assistance with bathing, dressing, and toileting and was not assisted resulting in the resident going without a shower for 21 days; and a resident who had a diagnosis of cerebral palsy and continent of bowel and bladder, being made to wear incontinent undergarments due to staff refusing to take her to the restroom and being made to go to bed earlier than desired (Resident #13). The facility failed to provide supervision for 2 of 3 sampled residents (Resident #3 and #4) residing in the Special Care Unit (SCU), who eloped from the SCU and were found in the parking lot of the facility; a resident who resided in the Assisted Living (AL), with wandering behaviors, exited the facility and crossed a busy 5 lane road in front of the facility with the intentions to go to her home and bank (Resident #5); and a resident in the Assisted Living (AL) facility who had a signed physician's order to be placed in the SCU since April of 2021, who required increased supervision, and continued to reside in the AL with behaviors unsafe to herself, staff and other residents with exit seeking, wandering and behaviors which were disruptive to other residents (Resident #6). The facility failed to notify the primary care physician (PCP) to meet the health care needs for a resident who was presenting with respiratory symptoms, lower extremity edema, falls which resulted in a facial and shoulder abrasion, and traumatic avulsion of a toenail and subsequently admitted to the hospital for acute cystitis and IV antibiotics, a speech evaluation for swallowing issues, dressing changes to the toenail and evaluation of arterial insufficiency (Resident #2); a resident who did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 273	D980		

receive a cardiology evaluation for management of a pacemaker and anticoagulation therapy which was ordered 01/27/21 and 05/18/21 (Resident #5); and a resident who was ordered and went without a medication to treat and prevent blood clots for a month (Resident #18). The facility failed to ensure physician orders were implemented for residents with orders for the application and removal of thromboembolic deterrent hose (Resident #3 and #9) increasing the risk for lower extremity swelling, decreased circulation and blood clots. The facility failed to ensure medications were administered as ordered by the licensed prescribing physician for 2 of 4 residents observed during the morning medication pass including a medication used to treat depression (14) and a medication to decrease cholesterol which can lead to strokes (Resident #15).The facility failed to administer medications as ordered for 12 of 14 sampled residents related to medications to thin the blood which could lead to an increased risk of stroke and death, (Resident #14, #16 and #18), medications to prevent high blood pressure which increased the risk for heart attacks and strokes (Resident #13 and #18), a medication for a urinary tract infection which left untreated could lead to urosepsis (Resident #3), a diuretic which caused an increase in lower leg swelling and possible skin breakdown (Resident #12), and a breathing treatment for shortness of breath which could lead to acute breathing difficulties (Resident #8).The facility the facility failed to ensure the completion of 5, 10, or 15-hour medication aide training, medication aide exam, and medication administration clinical skills validation for 2 of 4 sampled staff prior to administering medications to the residents placing the resident at risk for medication administration errors. These failures resulted in serious physical harm and serious

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060132	A. BUILDING: _____ B. WING _____	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 274 neglect which constitutes an A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on July 8, 2021 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 12, 2021.	D980		