STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ON PROVIDENCE	**5114 PROVIDENCE ROAD CHARLOTTE, NC 28226**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey on September 9-11, 2015 with an exit conference via telephone on September 14, 2015.	D 000		
D 132	10A NCAC 13F .0406(b) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: Based on record review, observation and interviews the facility failed to assure that 1 of 5 sampled staff (Staff A) was tested for TB (tuberculosis) prior to employment. The findings are: Review of employee file for Staff A revealed: -Staff A was hired 2/01/11 as a Medication Aide (MA). -Staff A had documentation of having had a chest X-ray scan on 7/30/14. -The CT chest scan did not reference the X-ray was for the purpose of looking for evidence of TB and did not document Staff A being free of tuberculosis. -There was no documentation of Staff A having had a positive TB test. Interview with the Business Office Manager (BOM) on 09/11/15 at 3:45 pm revealed: -She used an internal tracking system called Dashboard remind her when TB tests were due.	D 132		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

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D 132	Continued From page 1 -She started working at the facility earlier this year (2015) and upon employment at the facility she was made aware the previous interim BOM had current staff already entered in the dashboard tracking system so she did not check current staff to ensure TB test were done. -She assumed everything was already in good order. -When she started working at the facility she utilized the dashboard system to track new employees to keep track of their TB tests and when their second step TB tests were due, if necessary. -Her understanding was that a chest x-ray was acceptable when there was documentation of a positive PPD. -She did not have any knowledge of Staff A's status regarding the status of her TB test. Telephone Interview with Staff A on 09/11/15 at 2:30 pm revealed: -She always tested positive for TB and therefore she had a chest X- ray to show she did not have active TB. -She last had a chest X-ray in 2010. -She supplied a copy of the chest X-ray results to the facility when she was hired. -She could not remember if the facility went over a TB symptom check list with her when she was hired.	D 132		
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	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

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D 276	Continued From page 2 (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure documentation and implementation of physician's orders for 2 of 8 sampled residents (#1 and #7) as related to accuchecks and application and removal of anti-embolism stockings and braces. A. Review of Resident #7's current FL2 dated 6/18/15 revealed: -Diagnoses included: diabetes, gastrointestinal bleed, hypertension, hypokalemia, falls, anemia and actinic kerotosis. -A physician's order for accucheck blood sugars twice daily before meals. (Checking blood sugar levels via fingerstick.) Interview with Resident Care Director on 9/11/15 at 2:00 pm revealed Resident #7 was admitted to the facility on 6/24/15. Review of Resident #7's Medication Administration Record (MAR) for June, 2015 revealed: -Accucheck blood sugars were not transcribed onto the MAR. -No documentation of blood sugar results were obtained in June 2015. Review of Resident #7's Medication Administration Record (MAR) for July, 2015 revealed: -Accucheck blood sugars were not transcribed onto the MAR.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ____ B. WING ____	09/14/2015

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SUNRISE ON PROVIDENCE	5114 PROVIDENCE ROAD CHARLOTTE, NC 28226

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D 276	Continued From page 3 -No documentation of blood sugar results were obtained in July 2015. Review of Resident #7's Medication Administration Record (MAR) for August, 2015 revealed: -Accucheck blood sugars were not transcribed onto the MAR. -No documentation of blood sugar results were obtained in August 2015. Review of Resident #7's Medication Administration Record (MAR) for September, 2015 revealed: -Accucheck blood sugars were transcribed onto the MAR to be obtained twice daily on Mondays, Wednesdays and Friday beginning on 9/11/15. -There was no documentation of blood sugar results were obtained in September 2015 before 9/10/15. -The first blood sugar result documented was 133 on 9/11/15 at 8:00 am. Review of Resident #7 's record revealed a fax cover sheet dated 9/04/15 questioning the physician if the facility should be taking blood sugars and the physician responded twice daily on Mondays, Wednesdays and Fridays. Interview with the Wellness Coordinator (WC) on 9/11/15 at 12:40 pm revealed: -She or the Resident Care Director (RCD) were responsible for making the MARs for new residents. -She was aware of Resident #7's FL2, dated 6/18/15, had orders for accuchecks to be done twice daily every day and caught this discrepancy while having done a record audit. -She sought clarification of orders from the physician when she noticed the discrepancy and	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ____ B. WING ____	09/14/2015

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D 276	Continued From page 4	D 276		

received clarification on 9/9/15.
-The clarification received did change the order from twice daily to twice daily on Mondays, Wednesday and Fridays only.

Interview with RCD on 9/11/15 at 12:45 pm revealed:
-She and the WC worked together to admit residents and they both would create the MARs for new residents upon admission.
-She would contact the physician if there was a discrepancy when comparing medication lists either provided by the hospital, nursing home or the family.
-She would not seek clarification or verification of medication orders if there was no discrepancies.

B. Review of Resident #1's current FL-2 dated 7/07/15 revealed:
-Diagnoses included of atrial fibrillation, right hip fracture, chronic obstructive pulmonary disease, hypertension, cerebral vascular accident, dementia and "hypoalonia".

Review of Resident #1's Resident Register revealed an admission dated of 6/25/12.

-The FL2 dated 7/07/15 did not have orders to check blood sugars, orders to apply and remove anti-embolism stockings daily or to apply a brace to right leg.

Review of Resident #1's subsequent physician's orders dated 7/9/15 did not have any orders to check blood sugars, to apply and remove anti-embolism stockings daily or to apply a brace to right leg.

Review of Resident #1's Medication Administration Records (MARs) for July, August

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ON PROVIDENCE	5114 PROVIDENCE ROAD CHARLOTTE, NC 28226

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D 276	Continued From page 5	D 276		

and September 2015 revealed:
-An entry for accuchecks to be taken before meals and at bedtime transcribed onto the MARs and scheduled for administration at 7:00 am, 11:00 am, 4:00 pm and 8:00 pm.
-There was no entry for application and removal of anti-embolism stockings.
-There was no entry for the application and removal of a right leg knee brace.

Observation of Resident #1 in the resident' room on 9/9/15 at 4:30 pm revealed:
-Resident resting in a lowered bed, white anti-embolism stockings on bilateral lower extremities.
-A leg brace present on Resident #1's right leg extending from mid-knee to his ankle.

Second observation of Resident #1 in the dining room on 9/10/15 at 5:04 pm revealed:
-Resident #1 was in dining room in a wheelchair with white anti-embolism stockings on bilateral lower extremities.
-A leg brace present on Resident #1's right leg extending from mid-knee to his ankle.

Third observation of Resident #1 on 9/11/15 at 2:15 pm revealed:
-Resident was in the atria with a family member sitting in a wheelchair with white anti-embolism stockings on bilateral lower extremities.
-A leg brace present on Resident #1's right leg extending from mid-knee to his ankle.

Review of Resident #1's record revealed:
-A Licensed Health Professional Support (LHPS) dated 08/07/15 listing tasks including application of anti-embolism stockings and braces, finger stick blood sugars and administration of medications through injections.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ON PROVIDENCE	5114 PROVIDENCE ROAD CHARLOTTE, NC 28226

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D 276	Continued From page 6	D 276		

Interview with a pharmacy representative on 9/10/15 at 4:41 pm revealed:
-In 2015, the pharmacy supplied new anti-embolism stockings for Resident #1 on 4/06/15, 6/11/15, 7/17/15 and 8/26/15 based on original order dated 10/20/13.
-The pharmacy did not provide the facility with treatment records, but with most other facilities the anti-embolism stockings were entered on a Treatment Administration Records (TAR's).
-The facilities that do not receive TAR's had the anti-embolism stockings entered on their MAR's.

Interview with Rsident Care Director (RCD) on 9/11/15 at 12:40 pm revealed:
-There was no documentation of staff applying and removing the anti-embolism stockings or the right leg brace on the MARs or daily care sheets.
-The facility did not TARs for documentation.
-The Care Managers (CMs) who provided morning and evening care were responsible for the application and removal of both the anti-embolism stockings and the right leg brace.
-The CMs did not have to document the application or removal of the anti-embolism stockings or the right leg brace unless there was a problem.
-The staff knew to apply anti-embolism stockings and braces because these were discussed in shift turn over meetings.

Review of The Daily Care Log for Resident #1 dated 9/06/15 revealed documentation by a CM stating, "This a.m. resident's right leg and foot very swollen. Resident's foot was discolored, blue/purple. Notified Med Tech; still applied T.E.D. hose (anti-embolism stockings)."

Interview with a Med Aide (MA) on 9/11/15 at 1:35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ON PROVIDENCE	5114 PROVIDENCE ROAD CHARLOTTE, NC 28226

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D 276	Continued From page 7	D 276		

pm revealed:
-She had never applied or removed anti-embolism stockings at this facility.
-She had never seen entries for a leg brace or anti-embolism stockings on Resident #1's MAR.
-She had noticed braces and anti-embolism stockings on residents that resided at the facility, but was not aware of who was responsible for applying and removing them.
-She had not seen documentation of the leg brace or anti-embolism stockings on the MARs.

Interview with a CM on 9/11/15 at 1:53 pm revealed:
-The CMs on third shift might apply the anti-embolism stockings, but if they were not on the residents she assisted in the mornings then she would apply them.
-Sometimes the MA applied the anti-embolism stockings and it would depend on who was working on the floor and on the medication cart.

Interview with a representative from Resident #1'sprimary care physician's office on 9/11/15 at 12:00 pm revealed:
-Resident #1 was seen by the Nurse Practitioner at the facility on 9/03/15 and they did have documentation of the lower extremity edema.
-The physician's office representative did not have further communication with the facility noted past 9/03/15.
-The physician's office representative did not have a record of Resident #1 having an order for anti-embolism stockings.
-The physician's office representative did not have a record of Resident #1 having an order for a right leg brace.

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	HAL060057	A. BUILDING: ____ B. WING ____	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 310	Continued From page 8	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure a Pureed diet for 1 of 6 sampled residents (Resident #8) was served as ordered. The findings are: Review of Resident #8's current FL-2 dated 5/12/15 revealed: -Diagnoses included dementia, atrial fibrillation, hypertension, anxiety, and status post subdural hematoma. -A "mechanical soft" diet was ordered by the physician. Review of the most recent facility's diet order sheet dated and signed by the physician on 6/11/15 revealed Pureed diet was selected for Resident #8. Review of the Therapeutic Diet list posted in the kitchen revealed Resident #8 was to receive a Pureed diet. Review of the Therapeutic Diet Menu spreadsheet for the lunch meal on 9/9/15 revealed: -A Pureed diet menu spreadsheet was available	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ____ B. WING ____	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ON PROVIDENCE	5114 PROVIDENCE ROAD CHARLOTTE, NC 28226

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D 310	Continued From page 9	D 310		

for use by the food service staff.
-Residents ordered a Pureed diet were to receive pureed cheese ravioli with marinara sauce, pureed lemon butter broccoli, pureed garlic bread, and pureed brownie.

Observation of the lunch meal in the Special Care Unit (SCU) dining room on 9/9/15 between 12:20 pm and 12:50 pm revealed Resident #8 was served:
-8 ounces of fruit juice and 6 ounces of water was at the place setting.
-Resident #8 was served pureed clam chowder soup as an appetizer.
-A sectioned plate containing pureed cheese ravioli with marinara sauce and broccoli was fed to Resident #8 by a Care Manager.
-After completion of the main entree, Resident #8 was served a non pureed brownie dessert with whipped cream and a cherry, which was fed to the resident by the Care Manager.
-The resident consumed 100% of meal, including the brownie with no difficulties.
-The resident consumed 100% of fruit juice and water.

Interview with the Reminiscence Coordinator on 9/9/15 at 6:40 pm revealed:
-The Care Managers used the diet reference book in the dining room for guidance with therapeutic diets.
-She was not aware that a regular brownie had been served to Resident #8 for the lunch meal.
-She would bring that to the staff's attention and remind them of the therapeutic diets to be used as a reference.

Interview with Dietary Services Coordinator on 9/10/15 at 10:50 am revealed:
-The dietary department was responsible for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ___ B. WING ___	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ON PROVIDENCE	**5114 PROVIDENCE ROAD CHARLOTTE, NC 28226**

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D 310	Continued From page 10 sending the pureed desserts on the food cart to the Special Care Unit (SCU). -The facility purchased individually packaged frozen pureed desserts. -He was not aware the staff had served Resident #8 a regular brownie with whipped cream and a cherry. -He was not aware that none of the pureed desserts were sent on the food cart. Interview with a Care Manager on 9/10/15 at 10:45 am revealed: -A regular brownie was served to Resident #8. -She was assigned to feed Resident #8 during the lunch meal on 9/9/15. -"It was an oversight on my part, I should have realized it when the designated server brought it to me." Interview with a Care Manager on 9/10/15 at 10:50 am revealed: -A regular brownie was served to Resident #8. -She was aware of the pureed diet order for Resident #8. -She thought the brownie was soft enough on the inside to be considered pureed. -The dietary department generally sends down individually packed pureed desserts to the SCU, but there were none on the food cart for that meal.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ON PROVIDENCE	**5114 PROVIDENCE ROAD CHARLOTTE, NC 28226**

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D 344	Continued From page 11 resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications and treatment orders were clarified by the prescribing practitioner when not dated within 24 hours of admission or when not clear or incomplete for 3 of 8 sampled residents (#1, #3 and #7) as related to medications, insulin dosage, accuchecks and application and removal of anti-embolism stockings and leg brace. A. Review of Resident #1's current FL-2 dated 7/07/15 revealed: -Diagnoses included of atrial fibrillation, right hip fracture, chronic obstructive pulmonary disease, hypertension, cerebral vascular accident, dementia and "hypoalonia". -An order for Novolog 12u three times a day before meals (A fast acting injectable medication used to lower blood sugar levels) -An order for Novolog per sliding scale three times daily and at bedtime: blood sugar 251-300 give 2 units; blood sugar greater than 300 give 3 units. -An order for Lantus 38 units at bed time (A long acting injectable medication used to lower blood sugar levels) Review of Resident #1's Resident Register	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 344	Continued From page 12 revealed an admission dated of 6/25/12. Review of the FL2 dated 7/07/15 revealed no orders to check blood sugars or to apply and remove anti-embolism stockings and right knee brace. Review of Resident #1's subsequent physician's orders dated 7/9/15 did not have any insulin orders, orders to check blood sugars, to apply and remove anti-embolism stockings daily or to apply a brace to right leg. Review of Resident #1's Medication Administration Record (MAR) for July, August and September 2015 revealed: -An entry for Novolog Flexpen 10 units three times daily before meals was transcribed onto the MAR and documented as administered daily at 7:00 am, 11:00 am and 4:00 pm. -An entry for accucheck blood sugars to be taken before meals and at bedtime was transcribed onto the MARs and blood sugars scheduled for administration at 7:00 am, 11:00 am, 4:00 pm and 8:00 pm. -An entry for Novolog Flexpen sliding scale insulin (SSI). For blood sugar between 251-300 give 2 units and for blood sugar greater than 300 give 3 units was transcribed onto the MAR. -There was no entry for application and removal of anti-embolism stockings. -There was no entry for the application and removal of a right leg knee brace. Observation of Resident #1 in the resident's room on 9/9/15 at 4:30 pm revealed: -Resident resting in a lowered bed, white anti-embolism stockings on bilateral lower extremities. -A leg brace present on Resident #1's right leg	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ____ B. WING ____	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ON PROVIDENCE	5114 PROVIDENCE ROAD CHARLOTTE, NC 28226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 13 extending from mid-knee to his ankle. Observation of Resident #1 in the dining room on 9/10/15 at 5:04 pm revealed: -Resident in dining room in a wheelchair with white anti-embolism stockings on bilateral lower extremities. -A leg brace present on Resident #1's right leg extending from mid-knee to his ankle. Observation of Resident #1 on 9/11/15 at 2:15 pm revealed: -Resident in the atria with a family member sitting in a wheelchair with white anti-embolism stockings on bilateral lower extremities. -A leg brace present on Resident #1's right leg extending from mid-knee to his ankle. Review of Resident #1's record revealed: -A Licensed Health Professional Support (LHPS) dated 08/07/15 listing tasks including application of anti-embolism stockings and braces, finger stick blood sugars and administration of medications through injections. -The insulin orders documented on the LHPS were inconsistant with what was being documented as administered. The LHPS stated dosage of insulin as: Novolog 100u/ml - 12u three times a day before meals. Novolog 100u/ml per sliding scale three times daily and at bedtime: blood sugar 251-300 give 2 units; blood sugar greater than 300 give 3 units. Lantus 100u/ml - 38 units at bedtime. Interview with a pharmacy representative on 9/10/15 at 4:41 pm revealed: -In 2015, the pharmacy supplied new anti-embolism stockings for Resident #1 on 4/06/15, 6/11/15, 7/17/15 and 8/26/15 based on	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

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D 344	Continued From page 14	D 344		

an original order dated 10/20/13.
-The pharmacy did not provide the facility with treatment records, but with most other facilities the anti-embolism stockings were entered on a Treatment Administration Records (TAR's).
-The facilities that do not receive TAR's had the anti-embolism stockings entered on their MAR's.

Interview with Resident Care Director (RCD) on 9/11/15 at 12:40 pm revealed:
-There was no documentation of staff applying and removing the anti-embolism stockings or the right leg brace on the MARs or daily care sheets.
-The facility did not use TARs for documentation.
-The Care Managers (CMs) who provided morning and evening care were responsible for the application and removal of both the anti-embolism stockings and the right leg brace.
-The CMs did not have to document the application or removal of the anti-embolism stockings or the right leg brace unless there was a problem.
-The staff knew to apply anti-embolism stockings and braces because these were discussed in shift turn over meetings.

Review of The Daily Care Log for Resident #1 dated 9/06/15 revealed documentation by a CM stating, "This a.m. resident's right leg and foot very swollen. Resident's foot was discolored, blue/purple. Notified Med Tech; still applied T.E.D. hose (anti-embolism stockings)."

Interview with a Med Aide (MA) on 9/11/15 at 1:35 pm revealed:
-She had never applied or removed anti-embolism stockings at this facility.
-She had never seen entries for a brace or anti-embolism stockings on Resident #1's MARs.
-She had noticed braces and anti-embolism

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

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SUNRISE ON PROVIDENCE	5114 PROVIDENCE ROAD CHARLOTTE, NC 28226

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D 344	Continued From page 15 stockings on other residents that resided at the facility, but was not aware of who was responsible for applying and removing them. -She had not seen documentation of the leg brace or anti-embolism stockings on the MARs. Interview with a CM on 9/11/15 at 1:53 pm revealed: -The CMs on third shift might apply the anti-embolism stockings, but if they were not on the residents she assisted in the mornings then she would apply them. -Sometimes MAs applied the anti-embolism stockings and it would depend on who was working on the floor and on the medication cart. Interview with a representative from Resident #1's primary care physician's office on 9/11/15 at 12:00 pm revealed: -Resident #1 was seen by the Nurse Practitioner at the facility on 9/03/15 and they did have documentation of the lower extremity edema. -The physician's office representative did not have further communication with the facility noted past 9/03/15. -The physician's office representative did not have a record of Resident #1 having an order for anti-embolism stockings. -The physician's office representative did not have a record of Resident #1 having an order for a right leg brace. C. Review of Resident #3's current FL-2 dated 6/12/15 revealed diagnoses included Alzheimer's Dementia, Atrial flutter status post pacemaker 5/16/15, history of pulmonary embolism, dyslipidemia, hypertension, anemia, history of coronary artery disease, and history of prostate cancer with seed implants.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ON PROVIDENCE	5114 PROVIDENCE ROAD CHARLOTTE, NC 28226

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D 344	Continued From page 16 Review of Resident #3's Resident Register revealed an admission date of 7/21/15. Review Resident #3's FL-2 dated 6/12/15 revealed the following medication orders: - Simvastatin 40mg daily (prescribed to treat high cholesterol), - ASA (aspirin) 81 mg daily (prescribed to help circulation), - Donepezil 10 mg daily (prescribed to treat dementia of the Alzheimer's type), - Fish oil/omega-3 fatty acids 1200 mg daily (prescribed to treat elevated triglycerides), - Ramipril 10 mg one daily (prescribed to treat high blood pressure), - Sertraline 50 mg daily (prescribed to treat depression), - Terozosin 10 mg daily (prescribed to treat high blood pressure and benign prostate hyperplasia). Review of Resident #3's record revealed no contact with the physician to clarify the above medication orders (written 39 days before admission)prior to administering the medications. Review of Resident #3's Medication Administration Record (MAR) for July 2015 revealed transcription and daily administration of the following medications from 7/21/15 to 7/31/15: - Simvastatin 40mg daily, - ASA (aspirin) 81 mg daily, - Donepezil 10 mg daily, - Fish oil/omega-3 fatty acids 1200 mg daily, - Ramipril 10 mg one daily, - Sertraline 50 mg daily, - Terozosin 10 mg daily, - Atenolol 25 mg (used to treat high blood pressure and help regulate heart rate). Review of the resident's record revealed a	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUNRISE ON PROVIDENCE	5114 PROVIDENCE ROAD CHARLOTTE, NC 28226

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D 344	Continued From page 17	D 344		

document faxed by the facility on 7/21/15, and received back on 8/06/15 from the referring physician for Resident #3 with information as follows:
- Resident receiving Atenolol 25 mg in the medications brought by the resident to the facility.
- The document requested clarification if the resident should be receiving Atenolol 25 mg.
-"Yes, Indefinitely" was the response documented on the fax.

Review of Resident #3's MAR for August 2015 revealed transcription and daily administration of the following medications from 8/01/15 to 8/31/15:
- Simvastatin 40mg daily,
- ASA (aspirin) 81 mg daily,
- Donepezil 10 mg daily,
- Fish oil/omega-3 fatty acids 1200 mg daily,
- Ramipril 10 mg one daily,
- Sertraline 50 mg daily,
- Terozosin 10 mg daily,
- Atenolol 25 mg daily.

Review of Resident #3's record revealed signed physician's orders dated 8/31/15 that included:
- Simvastatin 40mg daily,
- ASA (aspirin) 81 mg daily,
- Donepezil 10 mg daily,
- Fish oil/omega-3 fatty acids 1200 mg daily,
- Ramipril 10 mg one daily,
- Sertraline 50 mg daily,
- Terozosin 10 mg daily,
- Atenolol 25 mg daily.

Based on record review, observation and interviews on 9/10/15 and 9/11/15, Resident #3 was determined to be unable to provide reliable information related to his medications.

Interview with Wellness Coordinator (WC) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 344	Continued From page 18 9/11/15 at 12:40 pm revealed: -She or the Resident Care Director (RCD) were responsible for transcribing the MARs for new residents. -They checked the medications lists that the family provided or the medication list on the discharge summary and compared the medication list to the FL-2 medications. -If there were discrepancies between the lists they would call the primary care physician and clarify the orders. -They would not verify orders with the physician if there were no discrepancies, regardless of when the FL-2 was signed. -She was not aware the medications listed on the FL-2 required verification if the FL-2 was not signed and dated within 24 hours of admission to the facility. Interview with the RCD on 9/11/15 at 12:45 pm revealed: -She and the WC worked together to admit residents and they both would make the MARs for new residents upon admission. -She would contact the physician if there was a discrepancy when comparing medication lists whether provided by the hospital, nursing home or the family. -She would not seek clarification or verification of medication orders if there were no discrepancies. -She was not aware that the medication list on the FL-2 required verification if the FL-2 was not signed and dated within 24 hours of admission to the facility. Interview on 9/11/15 at 5:30 pm with the Executive Director revealed the WD and/or the RCD were responsible for assuring medications were correct for residents including verification and/or clarification of medication orders.	D 344		

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 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 observation, interview, and record review, the facility failed to assure the documentation of the administration of medications as ordered by the licensed prescribing practitioner for 1 of 2 residents ordered sliding scale insulin (SSI) (Resident #1) which included errors with administration for Novolog SSI, a medication for reducing blood sugar levels. The findings are: A. Review of Resident #1's current FL2 dated	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 20 7/07/15 included the following: -Diagnoses included of atrial fibrillation, right hip fracture, chronic obstructive pulmonary disease, hypertension, cerebral vascular accident, dementia and "hypoalonia". Review of Resident #1's Resident Register revealed an admission dated of 6/25/12. Review of Resident #1's Licensed Health Professional Support dated 08/07/15 included the following additional diagnosis of diabetes mellitus type 2. Review of the current FL2 dated 7/07/15 revealed an order for Novolog 12 units three times a day and according the sliding scale as follows: Blood sugar range between 251-300 - give 2 units. Blood sugar range between greater than 300 - give 3 units. (Novolog is a fast acting insulin used to decrease elevated blood sugars). Review of Resident #1's physician's orders dated 7/9/15 did not have any insulin orders. Review of Resident #1's Medication Administration Record (MAR) for July 2015 revealed: -Novolog Flexpen 10 units three times daily before meals was transcribed onto the MAR and documented as administered daily at 7:00 am and 4:00 pm. -Accucheck blood sugar before meals and at bedtime was transcribed onto the MAR and documented at 7:00 am, 11:00 am, 4:00 pm and 8:00 pm. -Novolog Flexpen SSI. For blood sugar between 251-300 give 2 units and for blood sugar greater	D 367		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ON PROVIDENCE	5114 PROVIDENCE ROAD CHARLOTTE, NC 28226

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D 367	Continued From page 21 than 300 give 3 units was transcribed onto the MAR. -Insulin per SSI was not documented as administered for 3 out of 5 opportunities as follows:. -On 7/02/15 at 8:00 pm, blood sugar result was 266 and no insulin was documented as administered. Resident #1 should have been administered 2 units. -On 7/03/15 at 4:00 pm, blood sugar result was 285 and no insulin was documented as administered. Resident #1 should have been administered 2 units. -On 7/19/15 at 4:00 pm, blood sugar result was 334 and no insulin was documented as administered. Resident #1 should have been administered 3 units. Review of Resident #1's MAR for August 2015 revealed: -Novolog Flexpen 10 units three times daily before meals was transcribed onto the MAR and documented as administered daily at 7:00 am and 4:00 pm. -Accucheck blood sugar before meals and at bedtime was transcribed onto the MAR and documented at 7:00 am, 11:00 am, 4:00 pm and 8:00 pm. - Novolog Flexpen SSI. For blood sugar between 251-300 give 2 units and for blood sugar greater than 300 give 3 units was transcribed onto the MAR. -Insulin per sliding scale was not documented as administered for 9 out of 11 opportunities as follows:. -On 8/01/15 at 7:00 am, blood sugar result was 309 and no insulin was documented as administered. Resident #1 should have been administered 3 units. -On 8/01/15 at 11:00 am, blood sugar result was	D 367		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ON PROVIDENCE	**5114 PROVIDENCE ROAD CHARLOTTE, NC 28226**

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D 367	Continued From page 22 254 and no insulin was documented as administered. Resident #1 should have been administered 2 units. -On 8/07/15 at 8:00 pm, blood sugar result was 271 and no insulin was documented as administered. Resident #1 should have been administered 2 units. -On 8/09/15 at 11:00 am, blood sugar result was 344 and no insulin was documented as administered. Resident #1 should have ben administered 3 units. -On 8/15/15 at 4:00 pm, blood sugar was 252 and no insulin was documented as administered. Resident #1 should have been administered 2 units. -On 8/26/15 at 8:00 pm, blood sugar result was 341 and no insulin was documented as administered. Resident #1 should have been administered 3 units. -On 8/30/15 at 11:00 am, blood sugar result was 272 and no insulin was documented as administered. Resident #1 should have been administered 2 units. Review of Resident #1's MAR for September 1 - September 11, 2015 revealed: -Novolog Flexpen 10 units three times daily before meals was transcribed onto the MAR and documented as administered daily at 7:00 am and 4:00 pm. -Accucheck blood sugar before meals and at bedtime was transcribed onto the MAR and documented at 7:00 am, 11:00 am, 4:00 pm and 8:00 pm. - Novolog Flexpen SSI. For blood sugar between 251-300 give 2 units and for blood sugar greater than 300 give 3 units was transcribed onto the MAR. -Insulin per sliding scale was not documented as administered for 6 out of 6 opportunities as	D 367		

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	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 23 follows: -On 9/01/15 at 4:00 pm, blood sugar result was 263 and no insulin was documented as administered. Resident #1 should have been administered 2 units. -On 9/02/15 at 4:00 pm, blood sugar result was 252 and no insulin was documented as administered. Resident #1 should have been administered 2 units. -On 9/04/15 at 4:00 pm, blood sugar result was 280 and no insulin was documented as administered. Resident #1 should have been administered 2 units. -On 9/05/15 at 11:00 am, blood sugar result was 449 and no insulin was documented as administered. Resident #1 should have been administered 3 units. -On 9/06/15 at 11:00 am, blood sugar result was 339 and no insulin was documented as administered. residnet #1 should have been administered 3 units. -On 9/11/15 at 11:00 am, blood sugar result was 263 and no insulin was documented as administered. Resident #1 should have been administered 2 units. Interview with a Medication Aide (MA) on 9/10/2015 at 12:54 pm revealed: -She was aware that Resident #1 had a sliding scale. -She was aware that Novolog should be administered if the blood sugar was above 250. -She was knowledgeable about sliding scale insulin and how to administer insulin according to the sliding scale. -She administered insulin according to the sliding scale according to Resident #1's blood sugar results, but was not sure how to document the insulin administration because there was no space to write it on the MARs.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

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SUNRISE ON PROVIDENCE	5114 PROVIDENCE ROAD CHARLOTTE, NC 28226

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D 367	Continued From page 24	D 367		

-She was aware she should rotate insulin injection sites.
-She was unable to choose a site for administration because previous administrations were not documented.
-She did not know where or how to document on the MARs for the quantity of additional insulin administered.

Interview with a MA on 9/10/15 at 4:05 pm revealed:
-She knew to give insulin per the sliding scale based on the blood sugar results.
-She was unable to show where the MA had been administering the sliding scale insulin when the resident's blood sugar was above parameters.

Interview with Resident Care Director (RCD) on 9/11/15 at 11:20 am revealed:
-She completed initial training with staff as well as annual training on Diabetes which included administration and documentation of insulin per sliding scale.
-She provided a policy for common sites used for insulin injections and different types of insulin.
-She had no written policy for insulin administration per sliding scale.
-She was not aware that staff were not documenting if they were administering insulin, how much insulin they were administering or what injection site they utilized to administer the insulin.

Interview with Medical office Assistant at Resident #1's primary care physician's office on 9/11/15 at 12:00 pm revealed:
-The office had no record of the facility notification of sliding scale errors.
-There had no record of a recent Hemoglobin A1C (a blood test that gives an average blood sugar percentage) available.

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	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 25 -She wanted to have the office Nurse Manager to call back and discuss further as she may have been able to access more information. Physician Office Nurse Manager was unavailable for interview on 9/11/15 at 12:40 pm.	D 367		
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	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ON PROVIDENCE	5114 PROVIDENCE ROAD CHARLOTTE, NC 28226

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D 468	Continued From page 26 which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that 3 of 6 Staff (Staff A, B, and C) working in the Special Care Unit (SCU) received the required 20 hours of training within six months of their hire date. The findings are: A. Review of Staff A's Personnel record revealed: -Staff A was hired 2/01/11 as a Medication Aide (MA) in the SCU. -There was no documentation of Staff A having completed the required 20 hours of SCU training within 6 months of hire. -There was documentation of training on 1/19/11 specific to the population served totaling 10 hours before Staff A's date of hire. -No documentation was in the record to show the additional required 10 hours of SCU training was obtained by Staff A. Telephone interview with Staff A on 09/11/15 at 2:30 pm revealed: -She received 4-5 days of training that included classes in both the classroom and online. -Trainings were required to be completed prior to working with the residents in the SCU. -She received trainings related to dementia and related topics several times throughout the year. -She was not aware of the required training hours from when she was hired. -She was not aware of who was responsible for keeping track of trainings as there have been multiple changes in management at the facility.	D 468		

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	HAL060057	A. BUILDING: ______ B. WING ______	09/14/2015

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D 468	Continued From page 27 -She was unable to validate if she had received a total of 20 hours training within 6 months of employment related to care of residents in the SCU. B. Review of Staff B's personnel record revealed: -Staff B was hired 3/21/14 as a Care Manager in the SCU . -There was no documentation Staff B completed the required 20 hours of SCU training within 6 months of hire. -There was no documentation of training, specific to the population, that had been completed within 6 months of hire. Telephone interview with Staff B on 09/11/15 at 2:15pm revealed: -She completed several trainings on the computer in addition to shadowing workers when she first started in her position. -The last training she remembered was in February 2015 and she thought the topic was about Dementia. -She was unaware of the number of required training hours that she needed to have for her position in the SCU. -The Buisness Office Manager (BOM) kept track of the training hours. C. Review of Staff C's personnel record revealed: -Staff C was hired 11/13/14 as a Care Manager in the SCU. -There was no documentation of Staff C having completed the required 20 hours of SCU training within 6 months of hire. -There was documentation of online training, specific to the population served dated 12/7/14 totaling 9.25 hours.	D 468		

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D 468	Continued From page 28	D 468		

Continued From page 28

Telephone interview with Staff C on 09/11/15 at 2:00 pm revealed:
-She completed SCU training over the first three days of employment.
-She also completed some online classes that she was required to finish within 2 weeks.
-She remembered completing multiple classes over multiple days.
-She was not aware of the SCU training requirements for her position.
-She stated that the Reminiscence Care Coordinator and the BOM keep track of the trainings.

Interview with the Reminiscence Care Coordinator on 09/11/15 at 12:15 pm revealed:
-The BOM maintained the records for the Special Care Unit trainings.
-The BOM tracked the trainings for the Special Care Unit.

Interview with the BOM on 09/11/15 at 12:30 pm revealed:
-She kept documentation of the orientation training and monthly skills building dementia training. This included any dementia training involved in orientation that was taught in the facility.
-She was not aware of the 20 hours of training, specific to the population that was required within 6 months of hire for the SCU staff.
-She stated that new SCU employees shadow staff on the unit for 3-4 days. She was unsure of how many hours each day they shadow, but assumed it was for an entire shift. The Reminiscence Care Coordinator signed off that the shadowing shifts had been completed.
-She was not aware of what training, if any, was offered to new staff to fulfill the specific 20 training hours specific to the population of the

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D 468	Continued From page 29 SCU.	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 observation, interview and record review, the facility failed to assure all residents receive care and services which are adequate, appropriate, and in compliance with federal and state laws and rules and regulations related to Ach Medication Aides; Training and Competency. The findings are: Based on observation, interview and record review, the facility failed to assure 1 of 3 sampled Medication Aides (MA) (Staff F) had successfully completed Medication Clinical Skills Checklist and completed the 15 hour training prior to administering medications. [Refer to Tag 935 G. S. 131D4.5B(b) Ach Medication Aides, Training and Competency (Type B Violation).]	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care	D935		

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D935	Continued From page 30 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 accordance with subsection (c) of this section. This Rule is not met as evidenced by:	D935		

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D935	Continued From page 31 TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure 1 of 3 sampled Medication Aides (MA) (Staff F) had successfully completed the Medication Administration Clinical Skills Checklist and completed the 15 hour training prior to administering medications. The findings are: Review of Staff F's personnel file revealed: -Staff F was hired as a Care Manager on 2/8/13 with an undetermined date of transfer to a Medication Aide (MA) position around Spring 2014. -Staff F passed the written Medication Aide Exam on 4/27/10. -There was no documentation that Staff F completed a Medication Administration Clinical Skills Checklist. -There was no documentation that Staff F completed the 15 hour MA training. Interview with Staff F on 9/11/15 at 12:40 pm revealed: -Staff F worked mainly on the Assisted Living Unit. -Staff F had worked in other facilities and was familiar with the Medication Administration Clinical Skills Checklist and had been checked off elsewhere. -Medication Administration Clinical Skills Checklist was completed at this facility with the previous Health and Wellness Nurse on an undetermined date. -She did not retain a copy of her training as a Medication Aide. -She did take the 15 hour Medication Aide Training with the nurse from the pharmacy on an	D935		

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D935	Continued From page 32 undetermined date with no copy of the training and the nurse was no longer with the company. -She had administered oral medications, nasal sprays, eye drops and transdermal patches on a regular basis at this facility. -She had applied clean dressing changes and obtained finger stick blood sugars on a regular basis at this facility. Interview with the Executive Director on 9/11/15 at 12:45 pm revealed: -The recent change of positions "the paperwork has just gotten lost". -Staff F would immediately go through the check off and training required. -There were no employment verifications completed on Staff F. ________________________ The facility provided a Plan of Protection on 09/11/15 which included the following: -Staff F would be removed from the medication cart and would complete the clinical skills validation and 15 hour training immediately. -The facility will complete medication administration competencies on all Med Care Managers before they are able to pass medications in the community. -This process will be monitored by the nurse and Business Office Coordinator upon hire and the Executive Director will monitor for completion monthly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, October 29, 2015.	D935		