STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 a follow-up survey 06/11/19-06/13/19.	{D 000}		
D 352	10A NCAC 13F .1003(a) Medication Labels 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed; (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date; (8) auxiliary statements as required of the medication; (9) the name, address, telephone number of the dispensing pharmacy; and (10) the name or initials of the dispensing pharmacist. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 medication bottles were properly labeled for 1 of 6 residents (Resident #2) observed during the morning medication pass on 06/11/19 and 06/12/19. The findings are:	D 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 352	Continued From page 1	D 352		

Review of Resident #2's FL2 dated 05/23/19 revealed diagnoses included Alzheimer's disease, vascular dementia, abnormal gait, restlessness and agitation.

a. Review of Resident #2's current FL2 dated 05/23/19 revealed:
-There was an order for quetiapine 100mg, (used to treat mental/mood conditions), one tablet every evening.
-There was an order for quetiapine 50 mg, one tablet in the morning and afternoon.

Review of a subsequent order dated 05/29/19 revealed an order for quetiapine 50mg one tablet twice daily.

Observation of Resident #2's medications available for administration on 06/11/19 at 9:30am revealed:
-The medication aide (MA) prepared 5 medications for administration to Resident #2.
-There was a medication bottle from a third-party pharmacy with a computer generated label affixed to the bottle.
-Resident #1's name was on the label with "quetiapine 100mg".
-There was additional information on the medication bottle in Spanish.
-The MA removed one quetiapine 100mg tablet from the resident's medication bottle.
-The MA halved the quetiapine tablet with the pill splitter.
-The MA did not verify the directions on the medication label with the directions on the eMAR entry before administering the quetiapine.

Review of Resident #2's May 2019 electronic medication administration record (eMAR) from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 352	Continued From page 2 05/24/19 through 05/31/19 revealed: -There was an entry for quetiapine 50mg one tablet to be administered at 8:00am. -Quetiapine 50mg was documented as administered at 8:00am from 05/24/19 through 05/31/19. Review of Resident #2's June 2019 eMAR from 06/01/19-06/12/19 revealed: -There was an entry for quetiapine 50mg one tablet in the morning to be administered at 8:00am. -There was documentation quetiapine 50mg was administered at 8:00am from 06/01/19 through 06/12/19. Observation of medications available for administration for Resident #2 on 06/11/19 at 9:40am revealed: -There was a medication bottle from a third-party pharmacy with a computer generated label affixed to the bottle. -Resident #1's name was on the label with "quetiapine 100mg". -There was additional information on the medication bottle in Spanish. -There were no English directions on the bottle. -Thirty tablets had been dispensed on 06/02/19. -There were 12 whole tablets remaining in the bottle. Refer to interview with the MA on 06/11/19 at 9:59am. Refer to interview with the Director of Resident Care (DRC) on 06/11/19 at 2:45pm. Refer to interview with the Administrator on 06/11/19 at 3:30pm.	D 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 352	Continued From page 3 b. Review of Resident #2's FL2 dated 05/23/19 revealed there was an order for valproic acid 240mg tablet, take twice a day before meals. Observation of Resident #2's medications available for administration on 06/11/19 at 9:45am revealed: -The MA prepared five medications for administration to Resident #2. -The MA removed one valproic acid tablet 250mg (used for the treatment of manic episodes related to bipolar disorders) from the resident's medication bottle dispensed by a third-party pharmacy. -There was additional information on the medication bottle in Spanish. -There were no English directions on the label as to dispense the medication. -The MA administered 4 whole tablets and one half tablet to Resident #2. -The MA did not verify the directions on the medication label with the directions on the eMAR entry before administering the valporic acid. Review of Resident #2's May 2019 eMAR from 05/23/19 through 05/31/19 revealed: -There was an entry for valproic acid 250mg to be administered daily at 8:00am and 8:00pm. -There was documentation valproic acid was administered twice daily at 8:00am and 8:00pm from 05/23/19 through 05/31/19. Review of Resident #2's June 2019 eMAR from 06/01/19 through 06/12/19 revealed: -There was an entry for valproic acid 250mg to be administered daily at 8:00am and 8:00pm. -There was documentation valproic acid was administered twice daily at 8:00am and 8:00pm from 06/01/19 through 06/12/19.	D 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 352	Continued From page 4 Observation of Resident #2's medications available for administration on 06/11/19 at 9:48am revealed: -There was a medication bottle from a third-party pharmacy with a computer generated label affixed to the bottle. -Resident #1's name was on the label with "valproic acid 250mg". -There was additional information on the medication bottle in Spanish. -There were no English directions on the bottle. -Thirty tablets had been dispensed on 06/02/19. -There were 10 whole tablets remaining in the bottle. Refer to interview with the MA on 06/11/19 at 9:59am. Refer to interview with the Director of Resident Care (DRC) on 06/11/19 at 2:45pm. Refer to interview with the Administrator on 06/11/19 at 3:30pm. Attempted review of a copy of the cart audits for May 2019 and June 2019 was not provided. _____ Interview with the MA on 06/11/19 at 9:59 am revealed: -Resident #2 was admitted to the facility a few weeks ago. -There was a language barrier with Resident #2 and additionally he had advanced dementia. -There was a language barrier with the family. -He was admitted with some medications from a local pharmacy. -The directions were in Spanish. -She did not speak Spanish and there was not a translator on staff. -She administered medications as they were	D 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 352	Continued From page 5	D 352		

written on the eMAR.
-She had not verified the orders on the eMAR with the physician orders.
-She knew best practice was to verify the direction on the medication label with the directions on the eMAR entry.

Interview with the Director of Resident Care (DRC) on 06/11/19 at 2:45pm revealed:
-She had been randomly auditing the charts for accuracy of orders due to problems with the facility's eMAR software and the pharmacy.
-The MAs were tasked with performing cart audits on 6 residents per shift Monday through Wednesday.
-They were to submit the completed cart audit forms to the DRC for review by Thursday.
-The cart audit included verifying the medication labels, the order entries on the eMAR and the physician orders were identical.
-Resident #2's cart audit should have been completed by the MAs.
-She did not know the medications from a third party pharmacy did not have directions in English.
-The MAs should have brought this to her attention.
-The MAs were supposed to read the information on the eMAR and compare the medication name, strength and directions from the medication label for each medication prior to administering the medication.
-She was responsible for reviewing the medication orders.
-The MAs should clarify any questions or discrepancies between the order entry and the medication label prior to administering medications.
-There were no Spanish translators on staff.

Interview with the Administrator on 06/11/19 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 352	Continued From page 6 3:30pm revealed: -It was the responsibility of the DRC to oversee the clinical aspects of the facility. -She did not know who checked Resident #2's medications when he was admitted to the facility. -The medication bottles should have the appropriate instructions for administration on the label. -The MAs should be comparing the order entries on the eMAR with the directions on the medication packaging as best practice before administering all medications. -The MAs should have informed the DRC the label on the medication bottle was in Spanish. -There were no Spanish speaking staff members at the facility.	D 352		
{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.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 7 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 2 of 7 residents (Residents #5 and #6) observed during the 8:00am medication pass on 06/11/19 and 06/12/19 regarding a medication to treat high blood pressure (Resident #5), and a transdermal patch used to treat dementia (Resident #6), and 4 of 5 residents sampled including errors in medications used to control elevated blood sugar after meals, leg pain and symptoms of gastroesophageal reflux disease (GERD) (Resident #1), a medications to treat inflammation, GERD, mood conditions and agitation (Resident #2), a medication for depression (Resident #5) and a medication for heartburn (Resident #3). The findings are: The medication error rate was 13.8% (percent) as evidenced by the observation of 4 errors out of 29 opportunities during the 9:20am medication pass on 06/11/19 and the 8:15am medication pass on 06/12/19. 1. Review of Resident #6's FL2 dated 10/23/18 revealed: -Diagnoses included Alzheimer dementia. -There was an order for an exelon transdermal patch 9.5mg every 24 hours(hr). Observation of the morning medication administration pass on 06/11/19 at 9:45am revealed: -The medication aide (MA) prepared eight medication tablets and one transdermal patch for	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 8	{D 358}		

administration to Resident #6.
-The MA administered the eight tablets with four ounces of water, applied gloves and dated the exelon 9.5mg/24hr transdermal patch.
-The MA removed the previous patch from the resident's mid back to the right of the spine and applied the new exelon patch to the mid back to the left of the spine.
-The previous patch was disposed in the trash with the MAs gloves and water cup.

Observation of Resident #6's medications available for administration on 06/11/19 at 10:10am revealed a box of exelon 9.5mg/24 hr transdermal patches to be administered daily, thirty patches dispensed on 04/23/19 with fifteen patches remaining in the box.

Review of Resident #6's May 2019 eMAR from 05/01/19 through 05/31/19 revealed:
-There was an entry for an exelon 9.5mg/24hr transdermal patch, remove the old patch and rotate sites, to be administered daily at 1:00am.
-The exelon patch was documented as not administered 26 of 31 opportunities, from 05/01/19 through 05/31/19.
-The reason documented was the exelon patch was administered on first shift.
-There was no documentation on the eMAR the exelon patch was administered on first shift.

Review of Resident #6's record revealed there was no documentation the exelon patch was administered at another time from 05/01/19 through 05/31/19.

Review of Resident #6's June 2019 eMAR from 06/01/19 through 06/11/19 revealed:
-There was an entry for an exelon 9.5mg/24hr transdermal patch, remove the old patch and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 9	{D 358}		

rotate sites, scheduled for administration at 1:00am.
-The exelon transdermal patch was documented as not administered at 1:00am from 06/01/19 through 06/05/19.
-The documented reason for not administering the exelon patch at 1:00am was " due to incorrect order times".
-The exelon patch was documented as administered daily at 8:00am from 06/06/19 through 06/11/19.

Interview with the medication aide (MA) on 06/11/19 at 10:25am revealed:
-She did not know why there were 15 exelon patches in the box dispensed on 04/23/19.
-She administered the exelon patch to Resident #6 when she worked the medication cart.
-She knew the exelon patch was to be administered daily, after removing the old patch.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/12/19 at 11:05am revealed:
-Exelon 9.5mg/hr was an active order for Resident #6.
-The original signed physician's order for the exelon patch was dated 07/27/18 with 11 refills.
-The most recent fill history for the exelon patches, in quantities of 30, were 4/23/19, 03/11/19, 01/21/19 and 11/25/18.
-The most recent signed physician's order with 11 refills was dated 05/28/19.
-No further refills for the exelon patch had been requested by the facility since 04/23/19.
-The exelon patches were not dispensed with the cycle fill medications every 28 days.
-The facility staff were responsible for ordering the exelon patches when needed.
-The default time entered by the order entry staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 10	{D 358}		

at the pharmacy was 1:00am unless otherwise indicated on the physician's order.
-The facility staff was responsible for changing the administration time based on their medication administration schedule.
-The pharmacy medication profile for residents did not interface with the facilities eMAR.
-The pharmacy could not view the administration documentation by the facility staff.

Interview with the Director of Resident Care (DRC) and the Administrator on 06/12/19 at 12:30pm revealed:
-She was responsible for reviewing the eMARs for correct times and medication orders.
-She relied on the MAs to bring eMAR errors to her attention.
-She entered orders onto the eMAR after the MA faxed a copy to the pharmacy.
-The pharmacy default time for an order was 1:00am.
-She did not know the exelon patch orders were keyed in at 1:00am daily.
-She did not know the MAs were not administering the exelon patch to Resident #6.
-She did not know why this was not discovered when the MAs did the cart audit.

Based on observations and interviews it was determined Resident #6 was not interviewable.

Attempted telephone interview with a third shift MA on 06/13/19 at 1:15pm was unsuccessful.

2. Review of Resident #5's current FL2 dated 10/19/18 revealed diagnoses included Alzheimer dementia, myocardial infarction and diabetes.

a. Review of Resident #5's FL2 dated 10/19/18 revealed there was an order for lisinopril 10mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 11 every day. Observation of the medication pass on 06/12/19 at 8:20am revealed: -There were seven medications enclosed in a multidose package. -The medication aide (MA) placed the medications into a medicine cup to administer to Resident #5. -The lisinopril tablet fell to the floor. -The MA disposed of the lisinopril tablet. -She recorded the medication as "Wasted" due to falling on the floor. -The remaining 6 medications were administered to Resident #5. -The MA did not remove a second lisinopril tablet from a new multidosing package to administer to Resident #5. Review of Resident #5's June 2019 electronic medication administration record (eMAR) from 06/01/19 through 06/12/19 revealed: -There was an entry for lisinopril 10mg tablet to be administered daily at 8:00am, from 06/01/19 through 06/12/19. -There was documentation the lisinopril tablet was administered daily at 8:00am from 06/01/19 through 06/12/19. Observation of Resident #5's medications available for administration on 06/12/19 at 8:15am revealed: -There were three additional multidose packages of medications containing lisinopril 10mg. -There were no individual blister packs of lisinopril 10mg on the medication cart. Interview with the MA on 06/12/19 at 8:30am revealed: -The correct procedure when a medication was	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 12	{D 358}		

dropped from a mutidosed package was to dispose of the medication and document it as "Wasted".
-She did not remember who instructed her of this process.
-She did not have any additional single blister pack lisinopril tablets to administer.
-She could not waste the other six medications for one lisinopril tablet.
-She did not report this to her supervisor.

Interview with the Director of Resident Care (DRC) on 06/12/19 at 2:15pm revealed:
-The MAs should open the multidose package of medication to retrieve a dropped medication.
-They should call the pharmacy in the event they have opened an additional multidose package of medication and request the pharmacy staff send a new multidose package.
-She had instructed the MAs to follow this process.
-"It was not acceptable to record a medication as not administered because it had dropped to the floor."

Telephone interview with a pharmacist at the facility's contracted pharmacy on on 06/12/19 at 11:05am revealed:
-Medications were sent to the facility on a 28 day cycle fill in multidose packaging.
-Insurance covered the cost for these medications for the 28 days.
-If the facility had need of additional medication before the fill date, a "Non Covered Form" must be submitted to the pharmacy billing department.
-A blister pack with the number of tablets of medication required until the next cycle fill date would be sent to the facility staff.
-The cost of the additional pills would be submitted to the Business Office Manager at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 13 facility. Interview with the Administrator on 06/13/19 at 2:30pm revealed: -The DRC was the supervisor of the MAs. -The DRC provided the direction to the MAs regarding policies and procedures of medication administration. -The DRC coordinated with the pharmacy staff as to the process for refilling medications that have been wasted. -She did not know the MA had not administered a blood pressure medication because it had fallen to the floor. 3. Review of Resident #1's FL2 dated 08/07/18 revealed diagnoses included Alzheimer dementia and pancreatitis. a. Review of Resident #1's FL2 dated 08/07/18 revealed there was an order for omeprazole 20 mg daily in the morning. Review of a subsequent physician's order dated 04/11/19 revealed: -There was an order to discontinue omeprazole 20mg daily. -There was an order to administer omeprazole 20mg twice a day at 8:00am and 8:00pm for the diagnosis of gastroesophageal reflux disease (GERD). Review of Resident #6's April 2019 electronic medication administration record (eMAR) from 04/01/19 through 04/30/19 revealed: -There was an entry for omeprazole 20mg daily, to be administered at 8:00am. -There was documentation omeprazole was administered once daily from 04/01/19 through 04/30/19.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 14 -There was no entry for omeprazole to be administered daily at 8:00pm from 04/11/19 through 04/30/19. -There was no entry for omeprazole 20mg to be administered twice daily. Review of Resident #6's May 2019 eMAR from revealed: -There was an entry for omeprazole 20mg daily, to be administered at 8:00am. -There was documentation omeprazole was administered once daily at 8:00am from 05/01/19 through 05/31/19. -There was no entry for omeprazole 20mg to be administered daily at 8:00pm from 05/01/19 through 05/31/19. -There was no entry for omeprazole 20mg to be administered twice daily. Review of Resident #6's June eMAR from 06/01/19 through 06/11/19 revealed: -There was an entry for omeprazole 20mg daily, to be administered at 8:00am. -There was documentation omeprazole was administered once daily from 06/01/19 through 06/11/19. -There was no entry for omeprazole 20mg to be administered daily at 8:00pm from 06/01/19 through 06/11/19. -There was no entry for omeprazole 20mg to be administered twice daily. Interview with the medication aide (MA) on 06/12/19 at 10:00am revealed: -MAs were responsible for faxing the medication orders to the pharmacy and then they were to give the order to the Director of Resident Care (DRC). -New orders received were entered on the eMAR by the DRC.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 15 -She administered medications as they appeared on the eMAR to administer. Interview with the DRC on 06/12/19 at 2:15pm revealed: -She did not know Resident #1's omeprazole 20mg was ordered twice a day as of 04/11/19. -She had not finished auditing the resident's charts since she began her position as DRC. Interview with the Administrator on 06/13/19 at 2:30pm revealed: -The DRC was the supervisor of the MAs. -The DRC provided the direction to the MAs regarding policies and procedures of medication administration. -The DRC coordinated with the pharmacy staff as regards order entry. -She did not know Resident #6 had not been administered the evening dose of omeprazole 20mg as ordered by the physician on 04/11/19. -It was the responsibility of the DRC to ensure orders were entered on the eMAR correctly. b. Review of the physician's order dated 03/20/19 revealed an order for a lidocaine patch to apply to the right foot daily for pain. Review of Resident #1's April 2019 electronic medication administration record (eMAR) from 04/01/19 through 04/30/19 revealed: -There was an entry for a lidocaine patch, apply one patch to the right foot daily, remove the old patch, scheduled to be administered at 8:00am. -There was documentation the lidocaine patch was administered daily at 8:00am, from 04/01/19 through 04/30/19. Review of Resident #1's May 2019 eMAR from 05/01/19 through 05/31/19 revealed:	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 16 -There was an entry for a lidocaine patch, apply one patch to the right foot daily, remove the old patch, scheduled to be administered at 8:00am. -There was documentation the lidocaine patch was administered daily at 8:00am, from 05/01/19 through 05/31/19. Review of Resident #1's June 2019 eMAR from 06/01/19 through 06/11/19 revealed: -There was an entry for a lidocaine patch, apply one patch to the right foot daily, remove the old patch. -There was documentation the lidocaine patch was administered daily at 8:00am, from 06/01/19 through 06/11/19. Observation of Resident #1's medications available for administration on 06/12/19 at 11:25am revealed there were no lidocaine patches on the medication cart or in the medication room for administration. Interview with the MA on 06/12/19 at 11:30am revealed: -She did not know Resident #1 had foot pain. -She did not know he received lidocaine patches for his right foot pain. -She had not administered lidocaine patches to Resident #1. -She had not seen any lidocaine patches on the cart for Resident #1. -She had not reported to her supervisor there was an order entry on the eMAR for lidocaine patches and none had been dispensed from the pharmacy. -She did not call the pharmacy to clarify the order or determine why the patches were not dispensed. -There were a lot of errors with the eMARS and she thought this was an error.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 17 Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/12/19 at 11:05am revealed: -The lidocaine patch, apply one patch to the right foot daily, remove the old patch, was an active order for Resident #6. -The original signed physician's order for the lidocaine patch was 03/20/19. -The lidocaine patches were not sent with the cycle fill medications every 28 days. -The facility staff were responsible for ordering the lidocaine patches when needed. -There had never been a request from the facility to dispense the lidocaine patches for Resident #1. -The lidocaine patches for Resident #1 were never dispensed to the facility. Interview with Resident #1 on 06/13/19 at 11:15am revealed: -He had pain in his right leg and foot daily. -He could not sleep at night at times due to the pain. -He had informed the staff and the primary care physician. -He had never been administered a patch on his right foot for pain. Observation of Resident #1's right foot on 06/13/19 at 11:15am revealed there was no lidocaine patch applied to the area. Interview with the primary care physician (PCP) on 06/12/19 at 2:50pm revealed: -She was not informed of recent episodes of foot pain. -She did not know the Lidocaine patch had never been administered to Resident #1. -She expected the staff to administer the	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 18 lidocaine patch as ordered. Interview with the responsible family member on 06/13/19 at 8:45am revealed: -The facility had been responsible for Resident #1's medications. -The medications were ordered through the facility at their pharmacy. -He had not brought in any medications for Resident #1. -He did not know of any lidociane patch for foot pain prescribed for Resident #1. c. Review of Resident #1's FL2 dated 08/07/18 revealed there was an order for sertraline 50mg one tablet daily. There was a physician's order dated 01/15/19 for sertraline 50mg, 3 tablets daily (150mg). Review of Resident #1's subsequent physician's order dated 04/11/19 revealed: -There was an order to discontinue all previous sertraline orders. -There was a physician order for sertraline 100mg take 2 tablets (200mg) every morning. Review of a second subsequent physician's order for Resident#1 dated 04/23/19 for sertraline 150mg every morning at 8:00am. Review of Resident #1's April 2019 eMAR from 04/01/19-04/30/19 revealed: -There was an entry for sertraline 50mg three tablets to be administered daily at 8:00am, from 04/01/19 through 04/30/19. -There was documentation sertraline 150mg was administered daily, 27 of 30 opportunities, from 04/01/19 through 04/30/19. -There was an entry for sertraline 100mg two	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 19 tablets to be administered daily at 8:00am from 04/10/19 through 04/30/19. -There was documentation sertraline 200mg was administered daily at 8:00am, 19 out of 20 opportunities, from 04/10/19 through 04/30/19. -There was no entry for sertraline 50 mg once daily. Review of Resident #1's May 2019 eMAR from 05/01/19-05/31/19 revealed: -There was an entry for sertraline 100mg two tablets (200mg) to be administered daily at 8:00am from 05/01/19 through 05/31/19. -There was documentation sertraline 200mg was administered daily at 8:00am from 05/01/19 through 05/31/19. -There was an entry for sertraline 50mg three tablets (150mg) to be administered daily at 8:00am, from 05/01/19 through 05/31/19. -There was documentation sertraline 150mg was administered daily at 8:00am from 05/01/19-05/31/19. Review of Resident #1's June 2019 eMAR from 06/01/19-06/11/19 revealed: -There was an entry for sertraline 100mg two tablets (200mg) to be administered daily at 8:00am, from 06/01/19 through 06/11/19. -There was documentation sertraline 200mg was administered daily at 8:00am from 06/01/19 through 06/11/19. -There was an entry for sertraline 50mg three tablets (150mg) to be administered daily at 8:00am from 06/01/19 through 06/11/19. -There was documentation sertraline 150mg was administered daily at 8:00am from 06/01/19 through 06/11/19. Observation of Resident #1's medications available for administration on 06/12/19 at	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 20 3:20pm revealed: -Resident #1's medications were provided by the pharmacy in a multidose package. -Sertraline 100mg two tablets (200mg) every morning was in the multidose package. -There were no sertraline 50mg three tablets (150mg) on the medication cart. Interview with the medication aide (MA) on 06/12/19 at 3:30pm revealed: -The sertraline tablets were included in the multidosing package sent with the monthly cycle fill medications. -Since the multi dose packaging had been dispensed, she administered all the medications in the multi dose package to the residents. -There were no additional blister packets of sertraline tablets to administer to resident #1. Interview with the DRC and Administrator on 06/12/19 at 1:40pm revealed: -She expected medication aides to administer medications as ordered. -Non-controlled medications could be discontinued from the eMAR system by the pharmacy or facility management. -She did not know there were several orders for sertraline on the eMAR for Resident #1. -She had been identifying chronic errors with the facility's eMAR system. -She had communicated problems with the eMAR system with the pharmacy and the facility's regional support team. d. Review of Resident #1's physician's order dated 02/04/19 revealed there was an order for Novolog 100units/ml inject 4 units three times a day with meals, hold if the resident does not eat. Review of a subsequent order from the physician	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 21 dated 05/09/19 discontinued the Novolog 100units/ml 4 units three times a day with meals. Review of Resident #1's April 2019 eMAR from 04/01/19 through 04/30/19 revealed: -There was an entry for Novolog 100units/ml inject 4 units with meals three times a day, hold if the resident does not eat, scheduled to be administered at 8:00am, 12:00pm and 5:00pm. -There was documentation Resident #1 was administered 4 units of Novolog with meals three times a day administered at 8:00am, 12:00pm and 5:00pm from 04/01/19 through 04/22/19. -There was no documentation Resident #1was administered Novolog 4 units with meals three times a day at 8:00am, 12:00pm and 5:00pm from 04/23 through 04/30/19. Review of Resident #1's May 2019 eMAR from 05/01/19 through 05/09/19 revealed there was no entry on the eMAR for Novolog 4 units three times a day with meals. Observation of Resident #1's medications available for administration on 06/12/19 at 3:25pm revealed: -There was a vial of Novolog 100units/ml insulin dispensed by the pharmacy on 04/23/19 on the medication cart. -There was a handwritten entry on the insulin vial box with an opened date of 04/26/19 and an expiration date of 05/26/19. Interview with the medication aide (MA) on 06/12/19 at 10:00am revealed: -The pharmacy staff or the Director of Resident Care (DRC) could enter or discontinue orders on the eMAR. -The pharmacy staff discontinued orders on the eMAR when they received a signed physician's	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 22 order to discontinue. -The MAs could not enter or discontinue orders on the eMAR -She administered medications as the order appeared on the eMAR to administer. -If there was no order for insulin, she could not administer it. -She did not know the entry for the Novolog insulin for Resident #1 was dropped from the eMAR before the discontinue order was received from the physician. -"We have a lot of problems with orders dropping off the eMARs." Interview with the DRC on 06/12/19 at 12:30pm revealed: -She was responsible for entering medication orders on the eMAR system. -She entered orders onto the eMAR after the MA faxed a copy to the pharmacy. -At times, there was a delay in when orders were received because the fax machine was in the front of the building. -MAs were supposed to place orders in her box after they faxed them to the pharmacy. -The staff did not follow the medication order process as they have been instructed. -The MAs were assigned 3 residents per shift to audit their medications on the medication cart. -Medications on the cart were to be reconciled with the most current physician's order summary. -The MAs were also responsible for ordering medications when needed and removing expired medications from the medication carts. -She processed the order to discontinue Resident #1's Novolog insulin when she received the order in her box. -She had been finding physician orders "all over the place." -There was no one assigned to review the	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 23 eMARS for accuracy month to month. Telephone interview with the primary care physician (PCP) on 06/12/19 at 2:50pm revealed: -The facility had contacted her to discontinue Resident #1's Novolog insulin 4 units before meals, due to his fingerstick blood sugar (FSBS) readings. -She reviewed Resident #1's FSBS on 05/09/19 and discontinued the scheduled Novolog insulin 4 units before each meal. -She did not know Resident #1 had not been administered Novolog before meals from 04/23/19 through 05/09/19. -She expected the facility to carry out her orders as directed. Interview with the Administrator on 06/13/19 at 2:30pm revealed: -She did not know Resident #1 had not been administered Novolog insulin 4 units before each meal from 04/23/19 through 05/09/19. -Some medication orders had been "falling off the eMAR" recently. -The regional IT department was in the process of determining the reason for the eMAR discrepancies. -It was the responsibility of the DRC to ensure orders were entered on the eMAR correctly. 4. Review of Resident #2's FL2 dated 05/23/19 revealed diagnoses included Alzheimer's Disease, vascular dementia, abnormal gait, restlessness and agitation. a. Review of Resident #2's FL2 dated 05/23/19 revealed there was an order for prednisone 20mg (used to treat inflammation) two tablets every morning for three days, then one daily until	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 24 finished. Review of a subsequent order dated 05/29/19 revealed a physician order to administer prednisone 10mg one tablet daily for four days beginning 06/04/19, discontinue after four days. Review of Resident #2's May 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for prednisone 20mg two tablets daily with a start date of 05/24/19. -Prednisone 20mg two tablets was documented as administered 05/24/19-05/25/19, with a discontinue date of 05/25/19. -There was an entry for prednisone 20 mg one tablet daily until finished with a start date of 05/26/19. -Prednisone 20mg one tablet daily was documented as administered 05/26/19-05/30/19, with a discontinue date of 06/07/19. Review of Resident #2's June 2019 eMAR revealed: -There was an entry for prednisone 20mg one tablet daily at 8:00am until finished. -Prednisone 20mg was documented as administered 06/01/19-06/07/19, with a discontinue date of 06/07/19. -There was no entry for prednisone 10mg from 06/04/19-06/07/19 as ordered. Observation of Resident #2's available medications on 06/11/19 at 3:33pm revealed: -There was one bottle of prednisone 5mg tablets remaining available for administration. -The dispensed date on the bottle was 05/23/19. -The quantity dispensed was 40 tablets. Interview with a pharmacist from Resident #2's	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 25	{D 358}		

contracted pharmacy on 06/13/19 at 9:15am revealed:
-There were 40 tablets of prednisone 5mg dispensed on 05/23/19.
-The pharmacy never received an order dated 05/29/19 for prednisone 10mg.

Interview with a pharmacist at the facility's contract pharmacy on 06/12/19 at 11:07am revealed:
-The pharmacy did not receive the order dated 05/29/19 for prednisone 10mg.
- Resident #2 was listed as "profile only" in their system and no medications had been delivered.

Interview with the medication aide (MA) on 06/12/19 at 10:00am revealed:
-She administered Resident #2 prednisone 20mg 06/04/19-06/07/19.
-She did not know Resident #2 had an order for prednisone 10mg beginning 06/04/19.

Interview with the Director Resident Care on 06/12/19 at 06/12/19 at 12:30pm revealed:
-She did not know why Resident #2's prednisone 10mg order was not on the eMAR when it was ordered.
-She entered the order onto the MAR when she found the order in her box.

Interview with the primary care provider (PCP) on 06/12/19 at 11:16am revealed:
-Resident #2 was initially seen by her on 05/29/19.
-She did not know why Resident #2 was initially ordered prednisone.
-She wrote a new order for Resident #2's prednisone on 05/29/19 because the end date on the FL2 was unclear.
-She wanted Resident #2's prednisone to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 26	{D 358}		

decreased to 10mg before discontinuing the medication.
-Prednisone would need to be gradually decreased to prevent inflammation from reoccurring.

Attempted interview with Resident #2's Responsible Party (RP) on 06/11/19 at 3:26pm was unsuccessful.

Refer to interview with the medication aide (MA) on 06/12/19 at 10:00am.

Refer to interview with the Director Resident Care (DRC) on 06/12/19 at 12:30pm.

Refer to interview with the Administrator on 06/13/19 at 2:30pm.

b. Review of Resident #2's FL2 dated 05/23/19 revealed there was an order for omeprazole 20mg (used to treat acid reflux) twice daily.

Review of a subsequent order dated 05/29/19 revealed there was an order for omeprazole 20mg to be administered once daily.

Review of Resident #2's May 2019 eMAR revealed:
-There was an entry for omeprazole 20mg twice daily between meals.
-Omeprazole 20mg was administered twice daily from 05/29/19-05/31/19 at 10:00am and 3:00pm.
-Resident #2 continued to receive omeprazole 20mg twice daily in error from 05/29/19-05/31/19.

Review of Resident #2's June 2019 eMAR revealed:
-There was an entry for omeprazole 20 mg twice daily between meals from 05/24/19-06/07/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 27 -Omeprazole 20mg was administered twice daily from 06/01/19-06/07/19 at 10:00am and 3:00pm. -Resident #2 continued to receive omeprazole twice daily in error from 06/01/07-06/07/19. -There was an entry for omeprazole 20mg once daily beginning 06/08/19. Observation of Resident #2's available medications on 06/11/19 at 3:33pm revealed omeprazole 20mg was available for administration. Interview with Resident #2's contracted pharmacy on 06/13/19 at 9:15am revealed: -Sixty tablets of omeprazole 20mg was delivered 05/24/19. -The pharmacy never received an order dated 05/29/19 for omeprazole 20mg once daily. Interview with a pharmacist at the facility's contract pharmacy on 06/12/19 at 11:07am revealed: -The pharmacy never received the order dated 05/29/19 for omeprazole once daily. -Resident #2 was listed as "profile only" in their system and no medications had been delivered. Interview with the medication aide (MA) on 06/12/19 at 10:00am revealed: -She administered Resident #2 omeprazole 20mg as it instructed on the eMAR. -She did not know Resident #2 had an order for omeprazole 20mg once daily beginning 05/29/19. Interview with the DRC on 06/12/19 at 06/12/19 at 12:30pm revealed: -She did not know why Resident #2's omeprazole 20mg once daily order was not entered on to the eMAR until 06/08/19. - "Sometimes the medication order process is not	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 28 followed like they are supposed to". -She received the omeprazole order in her box late and entered it on the eMAR when she received the order. Interview with the primary care provider (PCP) on 06/12/19 at 11:16am revealed: -Resident #2 was initially seen by her on 05/29/19. -Resident #2 was ordered omeprazole for acid reflux. -She wrote a new order for Resident #2's omeprazole 20mg on 05/29/19 because she felt that the resident did not need it twice daily. -She wanted Resident #2's omeprazole 20mg to be decreased to once daily. -She expected the facility to follow orders as written. Attempted interview with Resident #2's Responsible Party (RP) on 06/11/19 at 3:26pm was unsuccessful. Refer to interview with the medication aide (MA) on 06/12/19 at 10:00am. Refer to interview with the Director Resident Care (DRC) on 06/12/19 at 12:30pm. Refer to interview with the Administrator on 06/13/19 at 2:30pm. c. Review of Resident #2's FL2 dated 05/23/19 revealed an order for quetiapine 100mg (used to treat mental/mood conditions) one tablet every evening, and quetiapine 50mg one tablet every morning and every afternoon. Review of a subsequent order dated 05/29/19 revealed an order for quetiapine 50mg one tablet	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 29 twice daily. Review of Resident #2's May 2019 eMAR revealed: -There was an entry for quetiapine 100mg one tablet at 8:00pm. -Quetiapine 100mg was administered at 8:00pm from 05/30/19-05/31/19. -There was an entry for quetiapine 50mg one tablet at 8:00am. -Quetiapine 50mg was administered at 8:00am from 05/24/19-05/31/19. -There was an entry for quetiapine 50mg, the frequency and time administered was "other". -Quetiapine 50mg was administered with time documented as "other" from 05/30/19-05/31/19. Review of Resident's #2 June 2019 eMAR revealed: -There was an entry for quetiapine 100mg one tablet at 8:00pm. -Quetiapine 100mg was administered at 8:00pm from 06/01/19-06/06/19. -There was an entry for quetiapine 50mg one tablet at 8:00am. -Quetiapine 50mg was administered at 8:00am from 06/01/19-06/07/19. -There was an entry for quetiapine 50mg, the frequency and time administered was "other". -Quetiapine 50mg was administered with time documented as "other" from 06/01/19-06/04/19. Observation of Resident #2's available medications on 06/11/19 at 3:33pm revealed: -There were 19 quetiapine 100mg pills available for adminstration. -The quetiapine 100mg bottle had a dispense date of 06/02/19 with a total of 30 tablets dispensed.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 30 Interview with a pharmacist at Resident #2's contracted pharmacy on 06/13/19 at 9:15am revealed: -The pharmacy had not received an order dated 05/29/19 for quetiapine 50mg twice daily. -Sixty tablets of quetiapine 50mg were filled on 03/21/19 and 04/29/19. -Thirty tablets of quetiapine 100mg were filled on 06/02/19. Interview with a pharmacist at the facility's contract pharmacy on 06/12/19 at 11:07am revealed: -The pharmacy received the order dated 05/29/19 for quetiapine 50mg twice daily on 06/07/19. - Resident #2 was listed as "profile only" in their system and no medications had been delivered. Interview with the medication aide (MA) on 06/12/19 at 10:00am revealed: -She administered Resident #2 quetiapine as it instructed on the eMAR. -She did not know Resident #2 had an order for quetiapine 50mg twice daily beginning 05/29/19 until it appeared on the eMAR 06/07/19. Interview with the DRC on 06/12/19 at 12:30pm revealed: -She did not know why Resident #2's quetiapine 50mg twice daily order was not entered on to the eMAR until 06/07/19. - "Sometimes the medication orders process is not followed like they are supposed to". -She received the quetiapine order in her box late and entered it on the eMAR when she received it. Interview with the primary care provider (PCP) on 06/12/19 at 11:16am revealed: -Resident #2 was initially seen by her on 05/29/19.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 31 -Resident #2 was ordered quetiapine for agitation. -She changed Resident #2's quetiapine order to 50mg twice daily to address his behaviors. -She expected the facility to follow orders as written. Attempted interview with Resident #2's Responsible Party (RP) on 06/11/19 at 3:26pm was unsuccessful. Refer to interview with the medication aide (MA) on 06/12/19 at 10:00am. Refer to interview with the Director Resident Care (DRC) on 06/12/19 at 06/12/19 at 12:30pm. Refer to interview with the Administrator on 06/13/19 at 2:30pm. d. Review of Resident #2's FL2 dated 05/23/19 revealed an order for trazodone 50mg one tab three times daily as needed. Review of a subsequent physician's order dated 05/29/19 revealed an order for trazodone 50mg one tablet twice daily for anxiety, agitation, restlessness. Review of Resident #2's May 2019 eMAR revealed: -There was no entry for trazodone 50mg one tablet twice daily. -Trazodone 50mg was not administered twice daily as ordered from 05/29/19-05/31/19. -Resident #2's trazodone 50mg was documented as not administered 6 out of 6 doses from 05/29/19-05/31/19. Review of Resident #2's June 2019 eMAR	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 32 revealed: -There was an entry for trazodone 50mg one tablet twice daily at 8:00am and 8:00pm beginning 06/07/19. -Trazodone 50mg was not documented as administered twice daily from 06/01/19-06/06/19. -Resident #2's trazodone 50mg was documented as not administered 13 out of 22 doses from 06/01/19-06/11/19. Observation of Resident #2's medications on 06/11/19 at 3:33pm revealed trazodone 50mg was available for administration. Interview with Resident #2's contracted pharmacy on 06/12/19 at 9:15am revealed: -Sixty tablets of trazodone 50mg was dispensed on 04/03/19 and 06/02/19. -The pharmacy had not received the order dated 05/29/19 for trazodone 50mg twice daily. Interview with a pharmacist at the facility's contract pharmacy on 06/12/19 at 11:07am revealed: -The pharmacy received the order for trazodone 50mg twice daily on 06/07/19. - Resident #2 was listed as "profile only" in their system and no medications had been delivered. Interview with the medication aide (MA) on 06/12/19 at 10:00am revealed: -She administered Resident #2 trazodone 50mg as it instructed on the eMAR. -She did not know Resident #2 had an order for trazodone 50mg twice daily beginning 05/29/19. -Resident #2 was sent out on 06/02/19 after punching a MA in the face. Interview with the DRC on 06/12/19 at 12:30pm revealed:	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 33 -She did not know why Resident #2's trazodone 50mg twice daily order was not entered on to the eMAR until 06/07/19. - "Sometimes the medication orders process is not followed like they are supposed to". -She received the trazodone order late and entered it on the eMAR when she received it". Review of an incident report completed for Resident #2 on 06/02/19 revealed: -Resident #2 "struck a med tech in the face". -Resident #2 was sent out to the emergency room for an evaluation. -Resident #2 was sent back to the facility on 06/02/19 to follow-up with his PCP. Interview with the primary care provider (PCP) on 06/12/19 at 11:16am revealed: -Resident #2 was initially seen by her on 05/29/19. -Resident #2 was ordered trazodone for agitation, anxiety, and restlessness. -She wrote a new order for Resident #2's trazodone order to assist with agitation and restlessness. -If trazodone 50mg was administered as ordered it would address Resident #2's behaviors. -She expected the facility to follow orders as written. Attempted interview with Resident #2's Responsible Party (RP) on 06/11/19 at 3:26pm was unsuccessful. Refer to interview with the medication aide (MA) on 06/12/19 at 10:00am. Refer to interview with the Director Resident Care (DRC) on 06/12/19 at 06/12/19 at 12:30pm.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 34 Refer to interview with the Administrator on 06/13/19 at 2:30pm. 5. Review of Resident #5's FL2 dated 10/19/18 revealed diagnoses included Alzheimer's disease, psychosis, depression, and schizophrenia. Review of a subsequent order dated 04/29/19 revealed there was an order for Remeron 15mg (used to treat depression) every night at bedtime. Review of Resident #5's April 2019 eMAR revealed: -There was no entry for Remeron 15mg every night at bedtime. -Resident #5 missed 2 of 2 doses of Remeron 15mg from 04/29-04/30/19. Review of Resident #5's May 2019 eMAR revealed: -There was no entry for Remeron 15mg every night at bedtime. -Resident #5 missed 31 out of 31 doses of Remeron 15mg from 05/01/19-05/31/19. Review of Resident #5's June 2019 eMAR revealed: -There was an entry for Remeron 15mg one tablet to be administered at bedtime. -Mirtazapine 15mg was documented as administered from 06/04/19-06/11/19 at 8:00pm. -Resident #5 missed 3 out of 11 doses from 06/01/19-06/11/19. Observation of Resident #5's medications on hand on 06/11/19 at 3:33pm revealed 14 tablets of mirtazapine 15mg was available for administration and was dispensed on 05/29/19. Interview with Resident #5's contracted pharmacy	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 35 on 06/13/19 at 10:25am revealed: -The order for Remeron 15mg was received on 04/29/19. -The pharmacy dispensed 9 pills of Remeron 15mg on 05/29/19. -It could not be determined why Remeron 15mg was not dispensed until 05/29/19, if the order was received on 04/29/19. -The facility was responsible for requesting medications when needed from the pharmacy. Interview with the medication aide (MA) on 06/12/19 at 10:00am revealed: -She administered Resident #5's mirtazapine when it appeared on the eMAR. -She did not know Resident #5's mirtazapine was supposed to start on 04/29/19. Interview with the DRC on 06/12/19 at 06/12/19 at 12:30pm revealed: -She was responsible for entering medication orders on the eMAR system. -She entered orders onto the eMAR when she received them after the MA faxed a copy to the pharmacy. -There was a delay in when orders were received because the fax machine was in the front of the building. -MAs were supposed to place orders in her box after they faxed to the pharmacy. - "Sometimes the medication orders process is not followed like they are supposed to". -Some orders were found in med carts and in the trash and she was not sure if this order was initially misplaced. -She entered medication orders onto the eMAR when she received order. Interview with the primary care provider (PCP) on 06/12/19 at 11:16am revealed:	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 36 -Resident #5 was ordered Remeron 15mg by the mental health provider. -She expected the facility to follow orders as written. Interview with the mental health physician assistant (PA) on 06/13/19 at 12:00pm revealed: -He ordered Remeron 15mg for Resident #5 on 04/29/19 to treat depression. -He felt that Resident #5 really needed the Remeron 15mg due to her symptoms of depression. -If Resident #5 did not receive Remeron as ordered she could have increased sadness, depression, and trouble sleeping. Attempted interview with Resident #5's Responsible Party (RP) on 06/13/19 at 12:35pm was unsuccessful. Based on interview, record review, and observation, Resident #5 was not interviewable. Refer to interview with the medication aide (MA) on 06/12/19 at 10:00am. Refer to interview with the Director Resident Care (DRC) on 06/12/19 at 12:30pm. Refer to interview with the Administrator on 06/13/19 at 2:30pm. 7. Review of Resident #3's current FL-2 dated 05/17/19 revealed diagnoses of dementia, hypertension, hyperlipidemia, osteoporosis, gout. Review of Resident #3's physician order's revealed: -There was an order dated 04/12/19 for sodium bicarbonate 650mg tablet (used to treat	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 37	{D 358}		

heartburn) to be administered three times per day for 14 days.
-A physician signed medication clarification order dated 05/15/19 for sodium bicarbonate 650mg tablet to be administered three times per day.

Review of Resident #3's signed physician's orders dated 05/22/19 revealed sodium bicarbonate 650mg tablet was to be discontinued on 05/22/19.

Review of Resident #3's April 2019 eMAR revealed sodium bicarbonate 650mg tablet to be administered three times per day for 14 days was not listed on the eMAR.

Review of Resident #3's May 2019 eMAR revealed:
-An entry for sodium bicarbonate 650mg tablet to be administered three times per day was documented as administered one time on 05/20/19 at 8:00pm and three times a day on 05/21-05/31/19.
-There was a start date of 05/20/19 with an end date of 06/02/19.

Review of Resident #3's June 2019 eMAR revealed:
-There was an entry for sodium bicarbonate 650mg tablet to be administered three times per day was documented as administered one time on 06/01/19 and three times on 06/02/19.
-There was a start date of 05/20/19 with an end date of 06/02/19.

Observation of Resident #3's medications available for administration on 06/12/19 revealed:
- There was a card for sodium bicarbonate 650mg tablets of 12 tables dispensed on 4/12/19 with 9 tablets remaining in the blister pack

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 38	{D 358}		

medication card.
- There was a second card for sodium bicarbonate 650mg tablets of 42 tablets dispensed on 4/12/19 with 13 tablets remaining in the blister pack medication card.
- There was a card for sodium bicarbonate 650mg tablets of 24 tablets dispensed on 05/16/19 with 22 tablets remaining in the blister pack medication card.

Interview with Resident #3's physician on 06/12/19 at 11:15am revealed:
-She had ordered sodium bicarbonate 650mg tablet to be administered three times per day for Resident #3 on 04/12/19.
-She had ordered sodium bicarbonate 650mg tablet three times per day to improve Resident #3's kidney function.
-She expected the facility to start the sodium bicarbonate 650mg tablet three times per day as soon as possible in April 2019.
-She submitted a medication clarification order to the facilty on 05/15/19 because she had identified the medication had not been documented as administered from 04/12/19 to 05/15/19.
-She submitted a discontinue order for sodium bicarbonate 650mg tablet to the facility on 05/22/19.
-She expected the facility to discontinue sodium bicarbonate 650mg tablet on or about 05/23/19.
-She was not aware sodium bicarbonate 650mg tablet three times per day had been documented as administered 05/23/19-05/31/19 and 06/01/19-06/02/19.

Interview with a representative at the facility's contracted pharmacy on 06/12/19 at 1:00pm revealed:
-The pharmacy was responsible for filling all of Resident #3's medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 39 -The pharmacy had received an order for sodium bicarbonate 650mg tablet to be administered three times per day for 14 days on 04/12/19 with an end date of 04/26/19. -The pharmacy sent a blister pack medication card to the facilty on 04/12/19 with 12 tablets of sodium bicarbonate 650mg three times per day. -The pharmacy sent a blister pack medication card to the facilty on 04/12/19 with 42 tablets of sodium bicarbonate 650mg three times per day. -Sodium bicarbonate 650mg three times per day was added back to Resident #3's pharmacy profile on 05/16/19 at the facility's request. -The pharmacy received a discontinue order for sodium bicarbonate 650mg three times per day on 05/22/19 and updated Resident #3's pharmacy profile accordingly. -The eMAR should have reflected sodium bicarbonate 650mg three times per day was discontinued on 05/22/19. -The sodium bicarbonate 650mg three times per day should have automatically been removed from the eMAR system on 05/22/19. -The facility was responsible for assuring Resident #3's discontinued sodium bicarbonate 650mg medication was no longer administered. -She did not know why the facility continued to document administration of sodium bicarbonate 650mg three times per day after 05/22/19 through 06/02/19. -There was no documentation that Resident #3's sodium bicarbonate 650mg had been returned to the pharmacy. Interview with a medication aide on 06/12/19 at 12:20pm revealed: -She was responsible for administering Resident #3's medications. -Resident #3 had an order for sodium bicarbonate 650mg to be administered daily in	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 40 May 2019. -She was responsible for documenting the administration of Resident #3's medications. -She was not aware Resident #3's sodium bicarbonate 650mg tablet to be administered three times daily was listed on the June eMAR when the medication had been discontinued on 05/22/19 by facility staff. -Resident #3's medications were only to be administered as ordered by Resident #3's physician. -Resident #3's sodium bicarbonate 650mg three times per day should have been removed from the eMAR by the pharmacy or the Director of Resident Care (DRC). -Medication aides or the DRC were responsible for removing discontinued medications from the medication cart. -She did not know why Resident #3's sodium bicarbonate 650mg was still in the medication cart. Interview with the DRC on 06/12/19 at 1:40pm revealed: -She expected medication aides to administer medications as ordered. -She expected medication aides to only administer medications listed on the eMAR that had a valid physician's order. -She was not aware Resident #3's sodium bicarbonate 650mg tablet three times a day continued to be administered after Resident #3's physician discontinued the medication on 05/22/19. -Non-controlled medications could be discontinued from the eMAR system by the pharmacy or facility management. -She expected medication aides to remove discontinued medications from the medication cart immediately upon the medication being	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 41 removed from the eMAR system. -She had been identifying chronic errors with the facility's eMAR system whereby medications that had been discontinued from the eMAR continued to re-populate randomly. -She had communicated problems with the eMAR system with the pharmacy and the facility's regional support team. Based on observations, interview, and record review, Resident #3 was not interviewable. Refer to interview with the medication aide (MA) on 06/12/19 at 10:00am. Refer to interview with the Director Resident Care (DRC) on 06/12/19 at 12:30pm. Refer to interview with the Administrator on 06/13/19 at 2:30pm. --- Interview with the medication aide (MA) on 06/12/19 at 10:00am revealed: -MAs were responsible for faxing the medication orders to the pharmacy and then give the order to the Director of Resident Care (DRC). -New orders received were entered on the eMAR by the DRC. -She administered medications as they appeared on the eMAR to administer. Interview with the Director Resident Care on 06/12/19 at 06/12/19 at 12:30pm revealed: -She was responsible for entering medication orders into the eMAR system. -She entered orders onto the eMAR when she received them. -There was a delay in when she received orders because the fax machine was in the front of the	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 42 building. -MAs were supposed to place orders in her box after they faxed them to the pharmacy. Interview with the Administrator on 06/13/19 at 2:30pm revealed: -Medications discontinued by the physician and continued on the eMAR, medications with the incorrect dosages administered to residents, and medications ordered by physicians and not administered was a problem. -The fax machine where orders were received was in the receptionist front office. -When the order was received in the DRC office, the DRC would follow the order process system. -The MAs were not following the order process system-retrieving the orders from the front office fax machine to the medication room, faxing to the pharmacy and leaving a copy for the DRC. -The facility software team was working on developing a software program for the facility eMAR and the pharmacy computer to interface. -This would allow the pharmacy and the facility staff to see both sides of the order entry. -She did not know of the medication errors on the eMARs. _____ The facility failed to assure medications were administered as ordered for 2 of 7 residents observed during the medication passes and 4 of 5 sampled residents for record review. This failure resulted in Resident #1 not being administered Novolog insulin with meals, three times a day for 16 days, did not receive a pain patch prescribed on 03/20/19 and continued to complain of foot pain and missed 62 doses of a medication for gastro-esophageal disease (GERD). Resident #3 was administered 33 additional doses of sodium bicarbonate. This	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 43 failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 06/12/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 29, 2019.	{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).	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 44 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the electronic Medication Administration Records (eMARs) were accurate and complete for 4 of 5 sampled residents (Residents #1, #2, #3, and #5), as related to documentation of medications used to control elevated blood sugar after meals, leg pain and symptoms of gastroesophageal reflux disease (GERD) (Resident #1), medications to treat inflammation, GERD, mood conditions and agitation (Resident #2), and medications for depression (Residents #5 and #3). The findings are: 1. Review of Resident #1's FL2 dated 08/07/18 revealed diagnoses included Alzheimer's dementia and pancreatitis. a. Review of Resident #1's FL2 dated 08/07/18 revealed there was an order for omeprazole 20 mg daily in the morning. Review of a subsequent physician's order dated 04/11/19 revealed: -There was an order to discontinue omeprazole 20mg daily. -There was an order to administer omeprazole twice a day at 8:00am and 8:00pm for the diagnosis of gastro-esophageal reflux disease (GERD). Review of Resident #1's April 2019 eMAR from	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 45 04/01/19 through 04/30/19 revealed: -There was an entry for omeprazole 20mg daily, to be administered at 8:00am. -There was documentation omeprazole was administered once daily from 04/01/19-04/30/19. -There was no documentation of omeprazole 20mg to be administered twice a day at 8:00am and 8:00pm starting 04/11/19. Review of Resident #1's May eMAR from 05/01/19 through 05/31/19 revealed; -There was an entry for omeprazole 20mg daily, to be administered at 8:00am. -There was documentation omeprazole was administered once daily from 05/01/19-05/31/19. -There was no documentation omeprazole was administered twice a day at 8:00am and 8:00pm. Review of Resident #1's June eMAR from 06/01/19 through 06/11/19 revealed: -There was an entry for omeprazole 20mg daily, to be administered at 8:00am. -There was documentation omeprazole was administered once daily from 06/01/19-06/11/19. -There was no documentation omeprazole was administered twice daily at 8:00am and 8:00pm. Interview with the medication aide (MA) on 06/12/19 at 10:00am revealed: -MAs were responsible for faxing the medication orders to the pharmacy and then give the order to the Director of Resident Care (DRC). -New orders received were entered on the eMAR by the DRC. -She administered medications as they appeared on the eMAR to administer. Interview with the DRC on 06/12/19 at 2:15pm revealed: -She did not know Resident #1's omeprazole	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 46 20mg was ordered twice a day as of 04/11/19. -She had not finished auditing the resident's records since she began her position as DRC. Interview with the Administrator on 06/13/19 at 2:30pm revealed: -The DRC coordinated with the pharmacy staff as regards order entry. -She did not know Resident #6 had not been administered the evening dose of omeprazole 20mg as ordered by the physician on 04/11/19. -It was the responsibility of the DRC to ensure orders were entered on the eMAR correctly. b. Review of the physician's order dated 03/20/19 revealed an order for a lidocaine patch to be applied to the right foot daily for pain. Review of Resident #1's April 2019 eMAR from 04/01/19 through 04/30/19 revealed: -There was an entry for a lidocaine patch, apply one patch to the right foot daily, remove the old patch, scheduled for administration at 8:00am. -There was documentation the lidocaine patch was administered daily at 8:00am. Review of Resident #1's May 2019 eMAR from 05/01/19 through 05/31/19 revealed: -There was an entry for a lidocaine patch, apply one patch to the right foot daily, remove the old patch scheduled for administration at 8:00am.. -There was documentation the lidocaine patch was administered daily at 8:00am. Review of Resident #1's June 2019 eMAR from 06/01/19 through 6/11/19 revealed: -There was an entry for a lidocaine patch apply one patch to the right foot daily, remove the old patch scheduled for administration at 8:00am.. -There was documentation the lidocaine patch	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 47 was administered daily at 8:00am. Review of Resident #1's record revealed there was no documentation the lidocaine patch had been requested to be filled by the pharmacy. Interview with the MA on 06/12/19 at 11:30am revealed: -She did not know Resident #1 had foot pain. -She did not know he received lidocaine patches for his right foot pain. -She had not administered lidocaine patches to Resident #1. -She had not seen any lidocaine patches on the cart for Resident #1. -She had not reported to her supervisor there was an order entry on the eMAR for lidocaine patches and none had been dispensed from the pharmacy. -She did not call the pharmacy to clarify the order or determine why the patches were not dispensed. -There were a lot of errors with the eMARS and she thought this was an error. -Sometimes orders come up as not given after a medication pass and "you think you administered it" so you document as given. Interview with the primary care physician (PCP) on 06/12/19 at 2:50pm revealed: -She was not informed of recent episodes of foot pain. -She did not know the Lidocaine patch had never been administered to Resident #1. -She expected the staff to administer the lidocaine patch as ordered. Interview with the DRC on 06/12/19 at 2:15pm revealed: -She did not know Resident #1's lidocaine patch	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 48	{D 367}		

to be administered daily on his right foot had not been dispensed since the order date of 03/20/19.
-She did not know the lidocaine patch had not been dispensed or administered since the MAs were documenting the patch was administered.
-The MAs did not report the lidociane patches were not available for administration with an active order.
-She expected the MAs would inform the pharmacy or the management that the lidocaine patches were not dispensed.
-She had not finished auditing the resident's eMARs since she began her position as DRC.

c. Review of Resident #1's FL2 dated 08/07/18 revealed there was an order for sertraline 50mg one tablet daily.

Review of a physician's order dated 04/08/18 revealed an order for sertraline 100mg daily.

Review of a subsequent physician's order dated 04/11/19 revealed:
-There was an order to discontinue all previous sertraline orders.
-There was a physician order for sertraline 100mg take 2 tablets (200mg) every morning.

Review of a second subsequent physician's order dated 04/23/19 for sertraline 150mg every morning at 8:00am.

Review of Resident #1's April 2019 eMAR from 04/01/19 through 04/30/19 revealed:
-There was an entry for sertraline 50mg three tablets to be administered daily at 8:00am.
-There was documentation sertraline 150mg was administered daily, 27 of 30 opportunities, from 04/01/19 through 04/30/19.
-There was an entry for sertarline 100mg two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 49	{D 367}		

tablets to be administered daily from 04/10/19 through 04/30/19.
-There was documentation sertraline 200mg was administered 19 out of 20 opportunities from 04/10/19 through 04/30/19.

Review of Resident #1's May 2019 eMAR from 05/01/19 through 05/31/19 revealed:
-There was an entry for sertraline 100mg two tablets (200mg) to be administered daily at 8:00am.
-There was documentation sertraline 200mg was administered daily at 8:00am from 05/01/19 through 05/31/19.
-There was an entry for sertraline 50mg three tablets (150mg) to be administered daily at 8:00am.
-There was documentation sertraline 150mg was administered daily at 8:00am from 05/01/19 through 05/31/19.

Review of Resident #1's June 2019 eMAR from 06/01/19 through 06/11/19 revealed:
-There was an entry for sertraline 100mg two tablets (200mg) to be administered daily at 8:00am.
-There was documentation sertraline 200mg was administered daily at 8:00am from 06/01/19 through 06/11/19.
-There was an entry for sertraline 50mg three tablets (150mg) to be administered daily at 8:00am.
-There was documentation sertraline 150mg was administered daily at 8:00am from 06/01/19 through 06/11/19.

Interview with the medication aide (MA) on 06/12/19 at 3:30pm revealed:
-The sertraline tablets were included in the multidosing package sent with the monthly cycle

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 50 fill medications. -Since the multidose packaging had been dispensed, she administered all the medications in the multi dose package to the residents. -There were no additional blister packets of sertraline tablets to administer to Resident #1. Interview with the DRC and Administrator on 06/12/19 at 1:40pm revealed: -She expected medication aides to administer medications as ordered. -Non-controlled medications could be discontinued from the eMAR system by the pharmacy or facility management. -She did not know there were several orders for sertraline on the eMAR for Resident #1. -She had been identifying chronic errors with the facility's eMAR system. -She had communicated problems with the eMAR system with the pharmacy and the facility's regional support team. d. Review of Resident #1's physician's order dated 02/04/19 revealed there was an order for Novolog 100units/ml inject 4 units three times a day with meals, hold if the resident does not eat. Review of a subsequent order from the physician dated 05/09/19 to discontinue the Novolog 100units/ml 4 units three times a day before meals. Review of Resident #1's April 2019 eMAR from 04/01/19 through 04/30/19 revealed: -There was an entry for Novolog 100units/ml inject 4 units with meals three times a day - hold if the resident does not eat. -There was documentation Resident #1 received 4 units of Novolog with meals three times a day from 04/01/19 through 04/22/19.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 51 -There was no documentation Resident #1 received Novolog 4 units with meals three times a day from 04/23/19 through 04/30/19. Review of the May 2019 eMAR from 05/01/19 through 05/09/19 revealed there was no entry on the eMAR for Novolog 4 units three times a day with meals, to be administered at 8:00am, 12:00pm and 5:00pm. Interview with the medication aide (MA) on 06/12/19 at 10:00am revealed: -The pharmacy staff or the Director of Resident Care (DRC) could enter or discontinue orders on the eMAR. -The pharmacy staff discontinued orders on the eMAR when they received a signed physician's order to discontinue the medication. -The MAs could not enter or discontinue orders on the eMAR. -She administered medications as the order appeared on the eMAR to administer. -If there was no order for insulin, she could not administer it. -She did not know the entry for the Novolog insulin for Resident #1 was dropped from the eMAR before the discontinue order was received from the physician. -"We have a lot of problems with orders dropping off the eMARs." Interview with the DRC on 06/12/19 at 12:30pm revealed: -She was responsible for entering medication orders on the eMAR system. -She entered orders onto the eMAR when she received them after the MA faxed a copy to the pharmacy. -At times, there was a delay when orders were received because the fax machine was in the	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 52 front of the building. -MAs were supposed to place orders in her box after they faxed them to the pharmacy. -The staff did not follow the medication order process as they have been instructed. -The MAs were assigned 3 residents per shift to audit their medications on the medication cart. -Medications on the cart were to be reconciled with the most current physician's order summary. -The MAs were also responsible for ordering medications when needed and removing expired medications from the medication carts. -She processed the order to discontinue Resident #1's Novolog insulin when she received the order in her box. -She had been finding physician orders "all over the place." Interview with the Administrator on 06/13/19 at 2:30pm revealed: -She did not know Resident #1 had not been administered Novolog insulin 4 units before each meal from 04/23/19 through 05/09/19. -Some medication orders had been "falling off the eMAR" recently. -The regional (informational technology) IT department was in the process of determining the reason for the eMAR discrepancies. -It was the responsibility of the DRC to ensure orders were entered on the eMAR correctly. 3. Review of Resident #2's FL2 dated 05/23/19 revealed: -Review of Resident #2's FL2 dated 05/23/19 revealed diagnoses included Alzheimer's Disease, vascular dementia, abnormal gait, restlessness and agitation -There was an order for quetiapine 100mg (used to treat mental/mood conditions) one tablet every	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 53	{D 367}		

evening, and quetiapine 50mg one tablet every morning and every afternoon.

Review of a subsequent order dated 05/29/19 revealed an order for quetiapine 50mg one tablet twice daily.

Review of Resident #2's May 2019 eMAR revealed:
-There was an entry for quetiapine 50mg, the frequency and time administered was "other".
-Quetiapine 50mg was administered with time documented as "other" from 05/30/19-05/31/19.
-It could not be determined when the quetiapine 50mg dose was administered.

Review of Resident's #2 June 2019 eMAR revealed:
-There was an entry for quetiapine 50mg, the frequency and time administered was "other".
-Quetiapine 50mg was administered with time documented as "other" from 06/01/19-06/04/19 once daily.
-It could not be determined when the quetiapine 50mg dose was administered.

Interview with the medication aide (MA) on 06/12/19 at 10:00am revealed:
-The order had been discontinued but it did provide a time and instructions for administering.
-She did not know why the eMAR did not print out time or instructions.
-She could not remember what time she administered the quetiapine 50mg.

Interview with the Director of Resident Care (DRC) on 06/12/19 at 12:30pm revealed:
-She was responsible for entering medication orders on the eMAR system.
-She did not know why Resident #2's quetiapine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 54 50mg time and date were missing from the eMAR. -There was a "glitch" with the eMAR system. -There was information MAs could view that she could not view. -She did not know the time and frequency was missing until the eMAR was printed. Refer to interview with the Administrator on 06/13/19 at 2:30pm. 4. Review of Resident #5's FL2 dated 10/19/18 revealed: -Diagnoses included Alzheimer's disease, psychosis, depression, and schizophrenia. -There was an order for Levemir insulin inject 30 units twice daily. Review of a subsequent order dated 03/27/19 revealed an order for 70 units Levemir insulin at bedtime. Review of a subsequent order for Resident #5 dated 05/04/19 revealed an order for Levemir insulin inject 80 units at bedtime. Review of Resident #5's May 2019 eMAR revealed: -There was an entry for Levemir insulin inject 70 units at bedtime at 8:00pm. -Levemir 70 units was documented as administered 11/31 opportunities from 05/01/19-05/31/19. -There was an entry beginning 05/04/19 for Levemir inject 80 units bedtime at 8:00pm. -Levemir 80 units was documented at administered 26 out of 26 opportunities from 05/05/19-05/31/19. Review of Resident #5's June 2019 eMAR	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 55	{D 367}		

revealed:
-There was an entry for Levemir insulin inject 70 units at bedtime at 8:00pm.
-Levemir 70 units was documented as administered on 06/01/19.
-There was an entry beginning 06/11/19 for Levemir inject 80 units bedtime at 8:00pm.
-Levemir 80 units was documented at administered 6 out of 11 opportunities from 06/01/19-06/11/19.

Interview with the medication aide (MA) on 06/13/19 at 12:30pm revealed:
-New orders received are entered on the eMAR by the Director of Resident Care (DRC).
-She did not administer both orders, however documented in both entries as administered "by mistake".
-She could not remember if she told the DRC that two different orders were listed on the eMAR for insulin for Resident #5.

Interview with the DRC on 06/12/19 at 06/12/19 at 12:30pm revealed:
-She was responsible for entering medication orders on the eMAR system.
-She did not know Resident #5's the current and previous Levemir order was placed on the eMAR for May and June 2019 until she reviewed Resident #5's orders and MAR.

Refer to interview with the Administrator on 06/13/19 at 2:30pm.

5. Review of Resident #3's current FL-2 dated 05/17/19 revealed:
-Diagnoses of dementia, hypertension, hyperlipidemia, osteoporosis, gout.
-There was an order for sertraline 100mg (used to treat depression) tablet to be administered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 56 every night. Review of Resident #3's signed physician's orders dated 05/01/19 revealed an order for sertraline 100mg tablet to be administered daily. Review of Resident #3's May 2019 electronic Medication Administration Record (eMAR) revealed: -Sertraline 100mg tablet every day was documented as administered on 05/01-05/12/19. -Sertraline 100mg tablet every day was documented as not administered due to Resident #3's hospitalization on 05/13-05/15/19. -There was no documentation that Sertraline 100mg was administered from 05/16-05/31/19. Review of Resident #3's June 2019 eMAR revealed there was no entry for Sertraline 100mg daily. Interview with a medication aide on 06/12/19 at 12:20pm revealed: -Resident #3 had an order for sertraline 100mg to be administered daily. -She was responsible for documenting administration of Resident #3's medications. -She did not know Resident #3's sertraline 100mg tablet to be administered daily was not listed on the June eMAR. -She did not know why Resident #3's sertraline 100mg was not listed on the June 2019 eMAR. -The eMAR system used by the facility frequently had medication administration recording errors, such as duplicate medications listed, medications that did not show up, and medications with incorrect dosage or administration directions. Interview with the Director of Resident Care (DRC) on 06/12/19 at 1:40pm revealed:	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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 57 -She expected medication aides to document every medication administered to a resident. -She was not aware Resident #3's sertraline 100mg tablet every day was not listed on the June eMAR. -She expected medication aides to communicate to the DRC if a medication is available for administration but not listed on the eMAR to clarify if the medication should be administered or removed from the medication cart. -She had been identifying chronic errors with the facility's eMAR system whereby medications were listed in duplicate, did not show up, changed dosage information, or administration directions. -She had been communicating with the pharmacy, physician, and facility regional support staff to resolve eMAR issues. Refer to interview with the Administrator on 06/13/19 at 2:30pm. _____ Interview with the Administrator on 06/13/19 at 2:30pm revealed: -The fax machine where orders were received was in the receptionist front office. -There was a second fax machine ordered for the Director of Resident Care's office (DRC). -Medication orders and physician transmissions would go directly to the DRC office. -When the order was received in the DRC office, the DRC would follow the order process system. -The MAs were not following the order process system-retrieving the orders from the front office FAX machine to the medication room, faxing to the pharmacy and leaving a copy for the DRC. -She did not know of the inaccuracy of the eMARs.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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
{D912}	Continued From page 58	{D912}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to administering medication as ordered by a physician. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 2 of 7 residents (Residents #5 and #6) observed during the 8:00am medication pass on 06/11/19 and 06/12/19 regarding a medication to treat high blood pressure (Resident #5), and a transdermal patch used to treat dementia (Resident #6), and 4 of 5 residents sampled including errors in medications used to control elevated blood sugar after meals, leg pain and symptoms of gastroesophageal reflux disease (GERD) (Resident #1), a medications to treat inflammation, GERD, mood conditions and agitation (Resident #2), a medication for	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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
{D912}	Continued From page 59 depression (Resident #5) and a medication for heartburn (Resident #3). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	{D912}		