| Division of Fleating Service Regulation |  |  |                     |   |                                    |                          |
|---|--|--|---------------------|---|------------------------------------|--------------------------|
|   | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | E CONSTRUCTION  | (X3) DATE                          | SURVEY<br>LETED          |
| AND FLAM                                | GF GONNEG HON  | IDENTIFICATION NUMBER  | A. BUILDING:        |   | COMP                               | LETED                    |
|   |  |  | D IAMAG             |   |                                    |                          |
|   |  | HAL060149  | B. WING             |   | 07/2                               | 9/2019                   |
| NAME OF F                               | ROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, 9      | STATE, ZIP CODE   |                                    |                          |
| EAST TO                                 | ANNE   | 4815 NOR   | TH SHARO            | N AMITY ROAD  |                                    |                          |
| EAST TO                                 | WINE   | CHARLOT  | TE, NC 282          | 205   |                                    |                          |
| (X4) ID<br>PREFIX<br>TAG                | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REPERENCED TO THE APPROVIDENCY)  | D BE                               | (X5)<br>COMPLETE<br>DATE |
| D 000                                   | Mecklenburg Count<br>Services (DSS) cor<br>complaint survey or   | ensure Section and the<br>ty Department of Social<br>educted a follow-up and<br>n 07/23/19 through 07/24/19,<br>estigation was initiated by the<br>/01/19. | D 000               | Responses to the cited deficiencies<br>constitute an admission or agreem<br>the facility of the facts alleged or conset forth in the statement of deficient<br>plan of correction is perpared soley<br>matter of compliance with the law. | ent by<br>inclusions<br>ncies, the |                          |
| D 219                                   | 10A NCAC 13F .06   | 06 Staffing Chart  | D 219               | 10A NCAC 13F .0606 Staffing Cha   | rt                                 |                          |
|   |  | 06 Staffing Chart<br>06 STAFFING CHART The<br>cifies the required aide,  |                     | Facility will ensure the number of a<br>staff are on site and available bas<br>current facility census and staffing<br>requirments.   | ed on the                          | 8/26/19                  |
|   | supervisory and ma<br>eight-hour shift in fa   | unagement staffing for each<br>acilities with a capacity or<br>re residents according to   |                     | ED, RCC, and/or DRC are reviewi<br>staffing schedules daily.  | ng                                 | 8/26/19                  |
|   | Rules .0601, .0603,<br>this Subchapter.<br>Bed Count Position<br>Shift Third Shift<br>21 - 30 Aide<br>Supervisor N<br>Not Required | , .0602, .0604 and .0605 of  |                     | ED, Business Office Manager<br>and/or Divisional Business Manag<br>are reviewing and monitoring<br>times cards daily to assure staffing<br>correct. Time cards will be monitor<br>for one month, then weekly, and re<br>there after.      | j is<br>red daily                  | 8/26/19                  |
|   | 500 feet and immed<br>31-40 Aide<br>Supervisor 8'<br>within 500 feet and<br>immediately av<br>Administrator                        | diately available.  16 16 16  8* In the building, or allable.**  |                     | ED and/or Divisonal VP of Operation monitoring staffing hours daily. ED Divisional VPof Operations will most affing hours daily times one mont will continue monitoring staffing hothere after.   | and/or<br>nitor<br>th. ED          | 8/26/19<br>y             |
|   | 41-50 Aide<br>Supervisor 8*<br>500 feet and immed  | 20 20 16<br>8* In the building, or within<br>diately available.**  |                     | Facility RCC, DRC and or ED will main<br>staffing schedule and adjust schedule<br>as needed to ensure required staff cov  |                                    | 8/26/19                  |
|   | Administrator<br>51-80 Aide<br>Supervisor 8*<br>500 feet and immed<br>Administrator  | 24 24 16<br>8* In the building, or within<br>diately available.**  |                     | Facility has implemented daily star<br>meetings with all department head<br>Scheduling and open positions are<br>discussed daily.   | 8,                                 | 8/26/19                  |

61-70 Aide

Division of Health Service Regulation
LANDIVATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

28 28 24

(X6) DATE

Karen Polce

Reviewed and acknowledged 09/09/19

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 1 D 219 D 219 Continued from page 1 Supervisor 8\* 8\* 4 hours within the Facility has implemented facility/4 hours within 500 feet and immediately Manager on Duty (MOD) program which 8/26/19 available.\*\* consist of key management team members, Administrator On call to include but not limited to the following: 32 32 24 71-80 Aide ED, RCC, DRC, Business Office Manager Supervisor 8 8 4 hours within the Life Enrichment Cooridnator, and Dietary facility/4 hours within 500 feet and immediately Manager. available.\*\* Administrator On call 81-90 Aide 36 36 24 Manager on Duty will complete a MOD 8/26/19 Supervisor 8 8 4 hours within the communication log which is reviewed facility/4 hours within 500 feet and immediately in daily stand up manager meetings available.\*\*

Facility has conducted a Job Fair to hire

additional staffing as needed. Interviews.

All facility staff have received training on

All facility staff have received training on

policies.

Clocking in/out and Time adjustment forms.

proper call out procedures and Attendance

Training included who to contact when calling

off shift as well as what to do if an employee

fails to show up scheduled shift.

hiring and training of new staff will be ongoind 8/12/19

8/7/19

8/20/19 &

8/20/19 &

8/20/19 &

8/22/19

8/22/19

8/22/19

Administrator 5 days/week: Minimum of 40

40 40 32

8\*\*

8\*\*

8\*\*

8

44 44 32

48 48 32

52 52 40

56 56 40

60 60 40

5 days/week: Minimum of 40

hours. When not in facility, on call.

hours. When not in facility, on call

hours. When not in facility, on call.

Aide Supervisor 8 Administrator

Aide

91-100 Aide

101-110

111-120

131-140

141-150

Supervisor 8

Administrator

121-130 Aide

Aide

Aide

| Division of Health Service Regulation |  |   |                     |  | I Of CIVIT        | AFFROVED                 |
|---------------------------------------|--|---|---------------------|--|-------------------|--------------------------|
| STATEMEN                              | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '               | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY                   |
|                                       |  | HAL060149   | B. WING             |  | 07/2              | 9/2019                   |
| NAME OF I                             | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, 8      | STATE, ZIP CODE  |                   | · -                      |
| EAST TO                               | OWNE   |   | TH SHARON           | N AMITY ROAD<br>205  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG              | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| D 219                                 | 151-160 Aide Supervisor 16 Administrator hours. When not ir 161-170 Aide Supervisor 16 Administrator hours. When not ir 171-180 Aide Supervisor 16 Administrator hours. When not ir 181-190 Aide Supervisor 16 Administrator hours. When not ir 191-200 Aide Supervisor 16 Administrator hours. When not ir 191-200 Aide Supervisor 16 Administrator hours. When not ir 201-210 Aide Supervisor 16 | 64 64 48 16 8 5 days/week: Minimum of 40 n facility, on call. 68 68 48 16 8 5 days/week: Minimum of 40 n facility, on call. 72 72 48 16 8 5 days/week: Minimum of 40 n facility, on call. 76 76 56 16 8 5 days/week: Minimum of 40 n facility, on call. 80 80 56 16 8 5 days/week: Minimum of 40 n facility, on call. 80 80 56 16 8 5 days/week: Minimum of 40 n facility, on call. 80 80 56 16 8 5 days/week: Minimum of 40 n facility, on call. 84 84 56 16 8 | D 219               |  |                   |                          |
|                                       | Administrator hours. When not in 211-220 Aide Supervisor 16 Administrator hours. When not in 221-230 Aide Supervisor 16 Administrator hours. When not in 231-240 Aide Supervisor 24 Administrator hours. When not in hours. When not in This Rule is not me  | n facility, on call. 88 88 64 16 16 5 days/week: Minimum of 40 n facility, on call. 92 92 64 16 16 5 days/week: Minimum of 40 n facility, on call. 96 96 64 24 16 5 days/week: Minimum of 40 n facility, on call.   |                     |  |                   |                          |

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 219 Continued From page 3 D 219 **TYPE A2 VIOLATION** Based on observation, interviews and record review, the facility failed to assure the required staffing hours were met on first, second and third shifts (7:00am-3:00pm, 3:00pm to 11:00pm and 11:00pm-7:00am) based on a census of 69 -72 residents, with 29 of 49 shifts sampled from 06/24/19 through 07/14/19 understaffed. The findings are: Review of the facility census, from 06/30/19-07/14/19, there was a census of 69 residents. Review of staff time cards for 06/30/19 through 07/14/19 revealed: -On 06/30/19, on first shift, there was a total of 24 hours of aid coverage with a shortage of 4 hours. -On 06/30/19, on second shift, there was a total of 25.5 hours of aid coverage with a shortage of 2.5 hours. -On 06/30/19, on third shift, there was a total of 16 hours of aide coverage with a shortage of 8 -On 07/01/19, on second shift, there was a total of 18.5 hours of aide coverage with a shortage of 9.5 hours. -On 07/01/19, on third shift, there was a total of 8 hours of aide coverage with a shortage of 16 hours. -On 07/03/19, on third shift, there was a total of 21.5 hours of aide coverage with a shortage of 3.5 hours. -On 07/04/19, on third shift, there was a total of 16 hours of aide coverage with a shortage of 8 -On 07/05/19, on second shift, there was a total

Division of Health Service Regulation

of 17.5 hours of aide coverage with a shortage of

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES

T(X1) PROVIDER/SUPPLIER/CLIA

| AND PLAN OF CORRECTION  (XT) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                     |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|--|---------------------|---|-------------------------------|--------------------------|
|   |   | HAL060149  | B. WING             |   | 07/:                          | 29/2019                  |
| NAME OF I   | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY.        | STATE, ZIP CODE   |                               |                          |
| EAST TO   | <b>WNE</b>  | 4815 NOR   |                     | N AMITY ROAD  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE                        | (X5)<br>COMPLETE<br>DATE |
| D 219   | Continued From pa   | ge 4   | D 219               |   |                               |                          |
| D 219   | 10.5 hoursOn 07/06/19, on se of 20 hours of aide hoursOn 07/06/19, on the of 8 hours of aide cohoursOn 07/07/19, on fir hours of aide coverationsOn 07/07/19, on se of 20.5 hours of aide coverationsOn 07/07/19, on the hours of aide coverationsOn 07/07/19, on the hours of aide coverationsOn 07/08/19, on se of 9.5 hours of aide cohoursOn 07/12/19, on se of 17 hours of aide cohoursOn 07/13/19, on fir 21 hours of aide cohoursOn 07/13/19, on se of 16 hours of aide cohoursOn 07/13/19, on se of 16 hours of aide cohoursOn 07/13/19, on se of 16 hours of aide cohoursOn 07/13/19, on se of 16 hours of aide cohoursOn 07/13/19, on se of 16 hours of aide cohoursOn 07/13/19, on se of 16 hours of aide cohoursOn 07/13/19, on se of 16 hours of aide cohours. | ge 4 econd shift, there was a total coverage with a shortage of 8 ird shift shift, there was a total overage with a shortage of 16 st shift, there was a total of 23 age with a shortage of 5 econd shift, there was a total ecoverage with a shortage of ird shift, there was a total ecoverage with a shortage of 16 econd shift, there was a total coverage with a shortage of 16 econd shift, there was a total coverage with a shortage of shird shift, there was a total coverage with a shortage of 8 econd shift, there was a total coverage with a shortage of 7 econd shift, there was a total of verage with a shortage of 7 econd shift, there was a total coverage with a shortage of 7 econd shift, there was a total coverage with a shortage of 7 econd shift, there was a total coverage with a shortage of 7 econd shift, there was a total coverage with a shortage of 7 econd shift, there was a total coverage with a shortage of 7 econd shift, there was a total coverage with a shortage of 7 econd shift, there was a total coverage with a shortage of 7 econd shift, there was a total coverage with a shortage of 7 econd shift, there was a total coverage with a shortage of 7 econd shift, there was a total coverage with a shortage of 7 econd shift, there was a total coverage with a shortage of 7 econd shift, there was a total of 2 econd shift, there was a total coverage with a shortage of 7 econd shift, there was a total of 2 econd shift, there was a total 2 econd shift a shortage of 3 econd shift a econd | D 219               |   |                               |                          |
|   |   | cond shift, there was a total overage with a shortage of 8   |                     |   |                               |                          |

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

HALO60149

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FORM APPROVED

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(7) PROVIDER OR SUPPLIER

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

07/29/2019

## **EAST TOWNE**

## 4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|--|---------------------|--|--------------------------|
| D 219                    | Continued From page 5  | D 219               |  | -                        |
| D 219                    | Continued From page 5 hoursOn 06/24/19, on third shift, there was a total of 16 hours of aide coverage with a shortage of 8 hoursOn 06/25/19, on second shift, there was a total of 12.5 hours of aide coverage with a shortage of 19.5 hoursOn 06/25/19, on third shift, there was a total of 13.5 hours of aide coverage with a shortage of 18.5 hoursOn 06/26/19, on third shift, there was a total of 16 hours of aide coverage with a shortage of 8 hoursOn 06/27/19, on third shift, there was a total of 21 hours of aide coverage with a shortage of 3 hoursOn 06/28/19, on second shift, there was a total of 20 hours of aide coverage with a shortage of 12 hoursOn 06/28/19, on third shift, there was a total of 20 hours of aide coverage with a shortage of 12 hours. | D 219               |  |                          |
|                          | 7.75 hours of aide coverage with a shortage of 16.25 hoursOn 06/29/19, on first shift, there was a total of 23 hours of aide coverage with a shortage of 9 hours -On 06/29/19, on second shift, there was a total of 22 hours of aide coverage with a shortage of 10 hoursOn 06/29/19, on third shift there was a total of 14 hours of aide coverage with a shortage of 10 hours.  |                     |  |                          |
|                          | Confidential interview with two staff revealed: -"Sometimes we are short staffed on the weekends"It was hard to get everything done on the weekends when only one medication aide (MA)/supervisor and one personal care aide (PCA) were working with a census of 70 residentsStaff complained to management but were told  |                     |  |                          |

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| MAME OF PROVIDER OR SUPPLIER  EAST TOWNE  SUMMARY STATEMENT OF DEFICIENCIES  (PACH ID PREFIX MAN AND PROVIDER OR SUPPLIAN OF DEFICIENCIES SHOWN AND PREFIX MAN AND PROVIDERS OF TAKE OF THE APPROPRIATE DEFOUNCE ON THE APPROPRIATE DEFOUNCE ON THE APPROPRIATE DESCRIPTION OF CORRECTION SHOULD SE CROSS-AFFERMENT OF DEFICIENCY ON THE APPROPRIATE DEFOUNCE ON THE APPROPRIATE DEFOUNCE ON THE APPROPRIATE DEFOUNCE ON THE APPROPRIATE DESCRIPTION OF THE APPROPRIATE DESCRIPTI |         | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | l ` '        | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED |
|--|---------|--|---|--------------|---|-------------------|-----------------|
| NAME OF PROVIDER OR SUPPLIER  EAST TOWNE  LUMMARY STATEMENT OF DEPROSENCES  CHARLOTTE, NC 28205  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  CHARLOTTE, NC 28205  PROVIDERS PLAN OF CORRECTION  CHARLOTTE, NC 28205  PROVIDERS PLAN OF CORRECTION  CHARLOTTE, NC 28205  PROVIDERS PLAN OF CORRECTION  PROVI |         |  |   | A. BOILDING  |   |                   |                 |
| ### CHARLOTTE, NC 28205    PRETIX   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDERS PLAN OF CORRECTION   |         |  | HAL060149   | B. WING      |   | 07/2              | 9/2019          |
| CHARLOTTE, NC 28205    Community   Charlotte   Charlot | NAME OF | PROVIDER OR SUPPLIER   |   |              |   |                   |                 |
| SAMMARY STATEMENT OF DEFICIENCIES (Fach DEFICIENCY)   SIMMARY STATEMENT OF DEFICIENCY STAGE   PROVIDER'S PLAN OF CORRECTION (Fach DEFICIENCY)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (Fach DEFICIENCY)   PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROP   | EAST TO | OWNE   |   |              |   |                   |                 |
| they were looking for more help. "I have trouble getting to everyone's needs when we are short staffed." -It was hard to answer all the call bells when we were short staffed.  Interview with the Resident Care Coordinator (RCC) revealed: -She was responsible for creating the staff work schedule and approving all changes to the schedule since 07/15/19She tried to staff first and second shifts with 3 medication aides (MAs) and 3 personal care aides (PCAs)She scheduled 12 hour shifts for the MAs on first and second shift to provide sufficient coverageOne of the MAs on each shift was the lead MA and supervised the shiftThe schedule was often made 2 weeks in advance so the census in the facility was not always reflected in the staffing.  Interview with the lead MA on 07/29/19 at 11:20pm revealed: -She had been responsible for the scheduling "for several months, under the supervision of the previous Administrator"The current RCC had requested the lead MA to continue to schedule the staff for the month of AugustShe had completed the August schedule at this timeShe did not request the census of the facility when creating the scheduleShe was told by the RCC to schedule 2 MAs and 3 PCAs per shiftThis was the only direction she received in creating a schedule.   | PRÉFIX  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO | D BE              | COMPLETE        |
| Interview with the Administrator on 07/29/19 at  | D 219   | they were looking for "I have trouble get we are short staffed. It was hard to answere short staffed. Interview with the R (RCC) revealed: -She was responsite schedule and approached since 07/-She tried to staff firmedication aides (Naides (PCAs)She scheduled 12 and second shift to -One of the MAs on and supervised the -The schedule was advance so the central ways reflected in supervious Administrative with the left: 20pm revealed: -She had been responsive with the left: 20pm revealed: -She had been responsive with the left: 20pm revealed: -She had been responsive with the left: 20pm revealed: -She had been responsive with the left: 20pm revealed: -She had been responsive with the left: 20pm revealed: -She had completed timeShe did not request when creating the second shiftThis was the only coreating a schedule creating a schedule | or more help. ting to everyone's needs when d." wer all the call bells when we desident Care Coordinator ble for creating the staff work owing all changes to the 15/19. It and second shifts with 3 MAs) and 3 personal care hour shifts for the MAs on first provide sufficient coverage. In each shift was the lead MA shift. In often made 2 weeks in usus in the facility was not the staffing. It and MA on 07/29/19 at the staffing of the supervision of the lead MA to e the staff for the month of the ditor". In add requested the lead MA to e the staff for the month of the August schedule at this of the census of the facility chedule. It is received in the century of the received in | D 219        |   |                   |                 |

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING:   |                     |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|---|---|---------------------|---|-------------------------------|--------------------------|
|  |   | HAL060149   | B. WING             |   | 07/2                          | 9/2019                   |
| NAME OF  | PROVIDER OR SUPPLIER  |   | DRESS, CITY, S      | STATE, ZIP CODE   |                               |                          |
| EAST TO  | OWNE  |   | TH SHAROI           | N AMITY ROAD<br>205   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE                        | (X5)<br>COMPLETE<br>DATE |
| D 219  | 10:20am revealed: -The RCC was respecteduleShe had been respected was not address according to the cearche RCC was to scensusShe thought this were not staffed according to the cearche she had delegated where not staffed according to the cearche staffThe previous Admischedule and provide staff's availability arache did not know in the current census.  REFER TO TAGS 2  The facility failed to hours were met for sampled from 06/22 resulted in a resider personal care assis #5); a lack of superdemonstrated aggrethreatening behavior (Resident #13); and | consible for creating the consible since 07/15/19. Was creating the schedule, sing the correct staffing rationsus. The factor of the resident as reflected in the schedule 4/19. Coverseeing the scheduling gated this to the RCC, here were several shifts that cording to the census. The responsible for scheduling mistrator would do the staff de her with a copy. The Administrator with the did requests for time off. The based the schedule on | D 219               |   |                               |                          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE S  A. BUILDING:  |                     |  |  |                               |
|--|--|---|---------------------|--|--|-------------------------------|
|  |  | HAL060149   | B. WING             |  | 07/2   | 0/2040                        |
| NAME OF I  |  |   |                     | CTATE ZID OODE   | 0112   | 9/2019                        |
|  | PROVIDER OR SUPPLIER   |   |                     | STATE, ZIP CODE<br>N AMITY ROAD  |  |                               |
| EAST TO  | WNE  |   | TE, NC 282          |  |  |                               |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)  | D BE   | (X5)<br>COMPLETE<br>DATE      |
| D 219  | period of time without emergency respond facility staff upon the Therefore, the facility staffing to meet the the residents at subneglect and constitution.  The facility provided accordance with G.  CORRECTION DATA VIOLATION SHALL 2019. | ge 8  ut staff's knowledge and ders being unable to locate eir arrival (Resident #9). ty's failure to assure minimal needs of the residents, put stantial risk for harm and utes a Type A2 violation.  d a plan of protection in S. 131D -34 on 07/29/19.  TE FOR THE TYPE A2 NOT EXCEED AUGUST 26, | D 219               | 10A NCAC 13F .0901(a) Personal Can   | e and  |                               |
|  | Supervision  10A NCAC 13F .096 Supervision (a) Adult care home care to residents acceptants and attend to needs residents matthemselves.  This Rule is not me  | 01 Personal Care and e staff shall provide personal coording to the residents' care any other personal care by be unable to attend to for et as evidenced by:   |                     | Supervision  Facility will ensure staff are providing p care to residents according to residents and/or any other personal care needs may be unable to attend to themselves Facility has completed an audit of all recare plans.  ED, RCC and/or DRC have updated recare plans based on residents current  ED, RCC and/or DRC will monitor and care plans for any resident who may have a significant change.  ED, RCC and/or DRC will ensure that admissions will have a complete care plans days of admission. | ersonal s care plar esidents esidents esidents needs. I update all new blan within | 8/26/19<br>8/26/19<br>8/26/19 |
|  |  | on, interviews, and record<br>ailed to provide personal care  |                     | Facility has completed full body assess all residents. Assessments were condudocumented by a Licensed RN.  |  | 8/26/19                       |

Division of Health Service Regulation

STATE FORM

(X3) DATE SURVEY

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| AND PLAN                 | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING              | :  | COMF                  | LETED                   |
|--------------------------|--|--|--------------------------|--|-----------------------|-------------------------|
|                          |  | HAL060149  | B. WING                  |  | 07/2                  | 9/2019                  |
| NAME OF                  | PROVIDER OR SUPPLIER   | 4815 NOF   |                          | STATE, ZIP CODE<br>N AMITY ROAD<br>205   | ,                     |                         |
| (X4) ID<br>PREFIX<br>TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE   |  | (X5)<br>COMPLETE<br>DATE |  |                       |                         |
| D 269                    | Continued From page  | ge 9   | D 269                    | Continued from page 9  |                       |                         |
|                          | sampled according  | residents (#2 and #5)<br>to the care plans related to<br>my care and personal care           |                          | Body audits were reviewed by DRC for needed follow-up.   | r any                 |                         |
|                          | and Resident #2 post-surgical care after a knee replacement.  The findings are:  Observation during the initial tour between 9:45am and 11:00pm revealed Resident #5 was in another resident's room and a urine / feces body odor was noted when she was interviewed by the survey team. |  |                          | Facility has implemented new shower and Shower Observation Sheet which completed by care staff after each resi   | is to be              | 8/26/19                 |
| ·                        |  |  |                          | receives a shower.  Shower Observation Sheets are placed wall box for review.  | d in DRC              |                         |
|                          |  |  |                          | Facility ED, RCC and/or DRC will revie<br>Shower Observation Sheets for any ne<br>follow up. Needed follow-up will be doc<br>in residents progress notes             | eded                  | 8/26/19                 |
|                          | 07/16/19 revealed: -Diagnosis included colostomy and deliri  | dent #5's current FL2 dated hypertension, diabetes, ium due to medical condition.            |                          | In the event that a resident refuses sch<br>showers, facility ED, RCC, DRC and/or<br>Designee will follow-up with resident ar<br>document in resident progress notes | r                     | 8/26/19                 |
|                          | "self".<br>Review of Resident  | stance was documented as<br>#5's Resident Register   |                          | All Care Staff have received training/in on new Shower Observation Sheets at to file for review.   | n-service<br>nd where | 8 /20/19<br>and 8/22/19 |
|                          |  | ion date of 10/10/18.<br>#5's current care plan dated  |                          | All Care Staff have received training/in<br>on Personal Care and assisting reside<br>ADLs.   |                       | 8/20/19<br>and 8/22/19  |
| :                        | -There was docume<br>colostomy but could<br>-There was docume  | ntation Resident #5 required   |                          | Management has implemented "Who and what I need" forms/binder  |                       | 8/26/19                 |
|                          | -There was docume  | e with bathing and showers.<br>entation Resident #5 required<br>e with toileting and hygiene |                          | "Who am I" forms reflect residents need personal care according to residents of plan.  |                       |                         |
|                          |  | signed by the facility<br>he physician.  |                          | The "Who am I" Binder will be located<br>nurses station and readily available fo<br>care staff.  |                       |                         |
|                          | member on 07/25/19   | with Resident #5's family<br>9 at 5:55pm revealed:<br>nily member had admitted<br>acility.   |                          | Facility ED, RCC, DRC and/or Desigr update "Who am I" form any time then change in residents care plan.  |                       | 8/26/19                 |

(X2) MULTIPLE CONSTRUCTION

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROV

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | E CONSTRUCTION  | (X3) DATE     | SURVEY<br>LETED          |
|--------------------------|--|--|---------------------|---|---------------|--------------------------|
|                          |  |  | A. BUILDING:        |   |               | LL   LD                  |
|                          |  | HAL060149  | B. WING             |   | 07/2          | 9/2019                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY,        | STATE, ZIP CODE   |               |                          |
| EAST TO                  | OWNE   |  | TH SHARO            | N AMITY ROAD<br>205   |               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)   | D BE          | (X5)<br>COMPLETE<br>DATE |
| D 269                    | Continued From pa  | ge 10  | D 269               | Continued from page 10  |               |                          |
|                          | staff Resident #5 w.<br>needing assistance<br>-Resident #5 had a<br>was unable to provi<br>-Resident #5 used p   | colostomy for 20 years but<br>de the care now.<br>paper towels and a "Depend"  |                     | All Facility Staff have been in-serviced on the "Who am I" Binder  Any new admissions to facility will hav am I" form completed at admission and as residents needs change. | e a "Who      | 8/20/19 &<br>8/22/19     |
|                          | belly that waste fror<br>instead of applying<br>-Resident #5 had a<br>at home from not cl<br>and not taking show   | foul smell of urine and feces nanging her colostomy bag  |                     | Facility ED, RCC and/or DRC have monitored resident colostomy care w for two weeks, then three times weeks.   |               | 8/26/19                  |
|                          | Administrator Residuith her colostomy  | ent #5 would need assistant  |                     | Facility ED, RCC, DRC and/or design<br>will continue radom skin assessment<br>needed care or follow-up  |               | 8/26/19                  |
|                          | home for a visit and fecesHe contacted the fa  | she had smelled of urine and acility staff over the weekend  |                     | Facility Care Staff have received train<br>in-service by a Licensed RN<br>on Colostomy Care Observation.  | ning/         | 7/29/19 &<br>8/26/19     |
|                          | #5 needed her color<br>someone at the faci   | and informed them Resident stomy bag checked and could lity check it.  dent #5 out of the facility on  |                     | Medication Aides have received train<br>in-service by a Licensed RN on Color<br>Care, Observation and reporting   | ing/<br>stomy | 7/29/19 &<br>8/26/19     |
|                          | July 4, 2019, he call<br>know to get Resider<br>colostomy bag and<br>-He thought the faci  | led the facility to let them<br>nt #5 ready and check her  |                     | All new hires to facility will recieve tra<br>Colostomy Care and Observation du<br>orientation  |               | 8/26/19                  |
|                          | family members on -Resident #5 was not colostomy or performmemory "slipping." -He admitted Reside another family mem-Resident #5 could bygiene or colostom | with another of Resident #5's 07/25/19 at 6:43pm revealed: ot able to care for her m personal care due to her ent #5 to the facility along with ber in October 2018. not care for her personal by at home. cility upon admission she |                     |   | į             |                          |

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 269 Continued From page 11 D 269 needed assistance with her colostomy. -Resident #5 would not apply the ostomy bag and used paper towels or a "Depend" to cover the -At home Resident #5 had an odor to her from the colostomy and smelled like feces. -The two family members could not care for Resident #5 at home so they placed her in the facility for personal care, showers and help with colostomy care. -Resident #5 could not perform colostomy care on her own. 1. Interview with a Personal Care Aide (PCA) on 07/23/19 at 2:15pm revealed: -She did not provide care or assist with emptying Resident #5's colostomy. -The MAs were to check the colostomy for Resident #5. -She was told Resident #5 did all her colostomy care herself. -She was aware Resident #5 had "body odor." -Some days you could not smell [Resident #5] because she wore a lot of perfume. Interview with a Medication Aide (MA) on 07/23/19 at 2:30pm revealed: -The MA do not change Resident #5's colostomy bag, the resident did everything herself. -If Resident #5 needed supplies she would ask for it. -"I have never smelled her". -Resident #5's family member did call the facility concerning the colostomy care about a month

Division of Health Service Regulation

ago.

-He had taken Resident #5 home and noticed an

-She did not know where Resident #5's colostomy

odor and thought it was coming from her

supplies were kept in the facility.

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING; \_. B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) D 269 Continued From page 12 D 269 Observation of Resident #5 on 07/24/19 at 8:40am revealed: -Resident #5 was dressed in slacks and a sweater. -Resident #5 had a foul smell when she walked toward the surveyor and a MA. -The MA ask Resident #5 to come into the medication room. -In the med-room the MA asked to see Resident #5's colostomy, when Resident #5 rolled the top of her slacks down there were paper towels covering the stoma without a colostomy bag intact. -The MA cleaned Resident #5 and applied a new colostomy bag to Resident #5's stoma. Interview with the MA who applied Resident #5's colostomy bag on 07/24/19 at 8:40am revealed: -She smelled Resident #5 and that is why she ask to see her colostomy on 07/24/19 in the medication room. -On 07/17/19 the physician wrote an order that the MAs are to check Resident #5's colostomy bag and the wafer (an adhesive baseplate that secures to the skin around the stoma holding the colostomy bag inplace) every shift. -Resident #5 did her colostomy herself. -She was unsure if any other MA were changing the bag, or if they even knew how. -The supplies are kept in the medication room and Resident #5 had supplies in her room.

Division of Health Service Regulation

in a hurry."

revealed:

Interview with Resident #5 on 07/24/19 at 8:45am

-"I guess I just used the paper towels cause I was

-She was in a hurry on 07/24/19 and forgot to

-Colostomy supplies were kept in her room.

apply the bag to her stoma.

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 269 D 269 Continued From page 13 -"My colostomy does leak at times and it does smell so "I try to cover the smell up with perfume." -Staff started checking her colostomy bag everyday about a week ago. Review of Resident #5's record revealed a signed physician's order dated 07/17/19 to check colostomy bag every shift change if needed, check colostomy wafer every shift and ensure it is in place. Observation of Resident #5 room on 07/24/19 at 3:15pm revealed, Resident #5 had colostomy supplies that were in her room. The supplies consisted of one colostomy bag and one wafer. Both, she pulled out from under a pillow on her bed. She did not have the other necessary supplies such as scissors or tape to apply the colostomy bag in her room. Interview with Resident #5 on 07/24/19 at 3:52pm revealed: -She completed colostomy care herself. -She needed the scissors to trim the wafer to fit the stoma prior to applying the colostomy bag. -She was unsure where the scissors were or when she had seen them last. -Her colostomy would leak at times, she used paper tape to secure the bag to her skin. -She was unsure where the tape was or when she had last used the tape.

Division of Health Service Regulation

colostomy.

at times to cover the stoma.

Telephone interview with Resident #5's Home Health Nurse on 07/24/19 at 4:05pm revealed: -She had seen Resident #5 once on 07/22/19 for an assessment and evaluation for care of the

-Resident #5 had told her she used paper towels

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 07/29/2019 HAL060149 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 269 Continued From page 14 D 269 -Resident #5 did complain to her that there was a smell to the colostomy and Resident #5 was embarrassed by the smell. -She was unsure how much Resident #5 could remember to complete her colostomy care on her own. -She completed education and would follow up with Resident #5 two times weekly. Interview with second PCA on 07/25/19 at 8:30am revealed: -The PCAs did not provide care or assist with emptying Resident #5's colostomy. -She was told by the MAs Resident #5 did her own personal care which included colostomy care. Interview with another MA on 07/25/19 at 9:50pm revealed: -Resident #5 did her own colostomy care. -I have never changed the colostomy bag for Resident #5. -The lead MA changed the bag if needed. -The order for checking the colostomy every shift is on the electronic Medication Administration Record (eMAR) so we check it off after we look at the colostomy. -That order started about a week ago but before then we were not checking Resident #5 colostomy. -Colostomy supplies are kept in the medication Interview with a third PCA on 07/25/19 at 11:32am revealed: -She had been working for about a month and half at the facility. -She had never changed Resident #5 colostomy bag. -She was told Resident #5 did her own colostomy

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B. WING\_ HAL060149 07/29/2019

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

## **EAST TOWNE**

## 4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|---|---------------------|---|--------------------------|
| D 269                    | Continued From page 15  | D 269               |   |                          |
|                          | careThe MAs should check Resident #5's colostomy bag and change it if neededShe did know Resident #5 used paper towels to cover the colostomyShe was aware Resident #5 had a foul smell "body odor" sometimesShe would tell the MAs and they would place a colostomy bag on Resident #5 when she told them"I think [Resident#5] forgets to put the bag on herself.  |                     |   |                          |
|                          | Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:25pm revealed: -She had worked in the facility for 3 weeksShe knew the physician had written an order to check Resident #5's colostomy and the wafer every shift on July 17, 2019She had requested the physician write the order on 07/17/19 because to Resident #5's had "a body odor which smelled like feces from the colostomy." -She was not aware one MA did not know where |                     |   |                          |
|                          | the supplies the colostomy supplies for Resident #5's were keptShe did not know MAs did not know how to provide colostomy care to Resident #5She did not know PCAs were not assisting with personal care for Resident #5 or emptying the colostomy bagShe expected the staff to assist and provide  |                     |   |                          |
|                          | personal care to Resident #5She knew Resident #5 had home health services since 07/22/19She had not completed the care plan dated 10/11/18 for Resident #5She was not aware of the care Resident #5 required on the care plan dated 10/11/18"If the care plan for [Resident #5] had extensive   |                     |   |                          |

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Division of Health Service Regulation

the task being performed.

Resident #5's colostomy.

with emptying the colostomy bag for Resident #5. -She did not know the PCAs were documented personal care completed without supervision of

-She thought Resident #5 had colostomy supplies in her room and could self-care for her colostomy. -Staff had not spoken to her with concerns for

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 269 D 269 Continued From page 17 Interview with a Lead Medication Aide (MA) on 07/29/19 at 4:10pm revealed: -She knew Resident #5 had her colostomy bag off at times, probably 2 or 3 times a week. -She knew Resident #5 used paper towels to cover the stoma and the paper towels would leak and cause Resident #5 to smell like feces. -She would change Resident #5's colostomy bag about ever other day, she was the only MA that knew how to change the bag. -She never told the physician about Resident #5 not having a colostomy bag on. -The PCAs do not check the bag or assist with emptying the bag or doing any personal care for Resident #5. -The MAs did not check Resident #5's colostomy until the physician wrote the order on 07/17/19. -The MAs are to make sure every shift Resident #5's colostomy bag is secured and document on the eMAR. Interview with the Administratoron 07/26/19 at 11:45am revealed: -She started as the Administrator three weeks -She knew resident #5 had a foul body odor around July 4, 2019 when Resident #5's family member contacted her. -She had a MA check her colostomy bag prior to the family taking Resident #5 out of the facility. -She did not know that staff were not assisting

Division of Health Service Regulation

Resident #5 with colostomy care.

bathing and toileting.

-She did know the physician had written an order on 07/17/19 to check the colostomy every shift. -She did not know Resident #5's care plan dated 10/11/18 had documented extensive care for

-She did not know Resident #5's care plan dated 10/11/18 had documented Resident #5 had a colostomy but could not provide self-care.

PHEM11

6899

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING \_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 269 Continued From page 18 D 269 -The staff were to assist and supervise Resident #5 colostomy care. -The care plans were to be followed so staff provided the appropriate care and services that are right for the residents. b. Review of Resident #5's current FL2 dated 07/16/19 revealed: -Diagnosis included hypertension, diabetes, colostomy and delirium due to medical condition. -Personal care assistance was documented as "self". Review of Resident #5's current care plan dated 10/11/18 revealed: -There was documentation Resident #5 had a colostomy but could not self care. -There was documentation Resident #5 required extensive assistance with bathing and showers. -There was documentation Resident #5 required extensive assistance with toileting and hygiene after toileting. -The care plan was signed by the facility representative and the physician. Interview with a Personal Care Aide (PCA) on 07/23/19 at 2:15pm revealed: -Resident #5 could perform all personal care on her own. -She did not provide assistance for Resident#5's showers or grooming. -She was aware Resident #5 had "body odor." -Some days you could not smell [Resident #5] because she wore a lot of perfume. Interview with a second PCA on 07/25/19 at 8:30am revealed: -Resident #5 could do all her ADLs herself which included washing her hair, taking a shower and changing her colostomy bag.

Division of Health Service Regulation

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 269 D 269 Continued From page 19 -Resident #5 is very private, "I think she takes a sponge bath because of the colostomy." -She charted Resident #5 baths were completed on the daily shower assignment sheet because "[Resident #5] tells me she had done her shower." -She never supervised Resident #5 to the shower room or handed her soap and a washcloth. Interview with a third PCA on 07/25/19 at 11:32am revealed: -She had worked in the facility for a month and half. -She was told Resident #5 did her own personal care. -She was aware Resident #5 had a foul smell "body odor" sometimes. -Resident #5 was "self-care" with showers and toileting. -"I ask her [Resident#5] if she showered and then document "Done" on the shower log." -She did not assist Resident #5 with any personal care task which included showers, washing hair or toileting. Review of the shower log for Resident #5 revealed showers were being documented as completed throughout the months of June 2019 and July 2019 three times weekly. Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:25pm revealed: -She had worked in the facility for 3 weeks. -She did not know PCAs were not assisting with personal care or showers for Resident #5. -She expected the staff to assist and provide personal care to Resident #5. -She knew Resident #5 had home health services

Division of Health Service Regulation

since 07/22/19.

-"If the care plan for [Resident #5] had extensive

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 20 D 269 D 269 care with toileting the staff should be assisting her with that task. -The care plans were completed by the facility nurse and reviewed in the morning meetings for new admissions. Interview with the facility LHPS Nurse on 07/26/19 at 1:50pm revealed: -She was responsible for completing and reviewing care plans for the residents in the facility. -She had not completed the care plan for Resident #5 on 10/11/19. -She was responsible for communicating with the floor staff how to provide care for the residents according to the care plans. -The person who completed Resident #5's care plan told me Resident #5 could do everything for -She did not know the care plan documented extensive care with personal care and toileting. -She did not know the PCAs were documented personal care completed without supervision of the task being performed. Review of Resident #5's psychotherapy notes dated 06/26/19 revealed:

Division of Health Service Regulation

-There was documentation Resident #5's hygiene

-There was documentation Resident #5 needed

Review of Resident #5's psychotherapy notes

-There was documentation Resident #5 had urinated on the seat of the community van while

-There was documentation Resident #5

-There was documentation Resident #5's hygiene

time for herself and increase self care.

was still often neglected.

dated 07/10/19 revealed:

was worsening again per staff.

attending the day program.

|                          | NT OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPL        | E CONSTRUCTION   | (X3) DATE |                          |  |
|--------------------------|--|--|---------------------|--|-----------|--------------------------|--|
| AND PLAN                 | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING:        |  | COMP      | PLETED                   |  |
|                          | I  |  |                     |  |           |                          |  |
| <u>.</u>                 |  | HAL060149  | B. WING             |  | 07/2      | 29/2019                  |  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, 8      | STATE, ZIP CODE  |           |                          |  |
| EAST TO                  | )WNE   |  |                     | N AMITY ROAD   |           |                          |  |
|                          |  | CHARLOT  | TTE, NC 282         | 205  |           |                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE     | (X5)<br>COMPLETE<br>DATE |  |
| D 269                    | Continued From pa  | ige 21   | D 269               |  |           |                          |  |
|                          | objectives were to t<br>activities of daily livi                         | take care of herself and her<br>ing.   |                     |  |           |                          |  |
|                          | Worker on 07/24/19<br>-Resident #5 was b                                 | dent #5's psychotherapy Social<br>9 at 12:55pm revealed:<br>seing seen for anxiety and                   |                     |  |           |                          |  |
|                          | depressionShe had worked with Resident #5 about 6 weeks in the facility. |  |                     |  |           |                          |  |
|                          | issue, Resident #5   | ent #5's hygiene would be an<br>had body odor that was<br>t of personal hygiene.                         |                     |  |           |                          |  |
|                          | -Resident #5 would   | I tell her she had showered<br>for her colostomy, "but I did not   |                     |  |           |                          |  |
|                          | believe her."  | staff that Resident #5 could   |                     |  | İ         |                          |  |
| ļ                        | benefit from assista<br>-The staff told me F                             | ance with her hygiene.<br>Resident #5 provided all her   |                     |  |           |                          |  |
|                          |  | boyfriend in the facility and  |                     |  |           |                          |  |
|                          | boyfriend.   | personal care due to this new  |                     |  |           |                          |  |
|                          | and her hygiene wa   | sident #5 again on 07/17/19<br>as still an issue and concern.<br>the RCC on 07/17/19 of<br>onal hygiene. |                     |  |           |                          |  |
|                          | 11:45am revealed:  | Administratoron 07/26/19 at  |                     |  |           |                          |  |
|                          | ago.<br>-She knew resident   | t #5 had a foul smell around   |                     |  |           |                          |  |
|                          | contacted her.   | Resident #5's family member sident #5 a shower prior to the  |                     |  |           |                          |  |
|                          | family taking Reside<br>-She did not know t                              | ent #5 out of the facility.<br>that staff were not assisting   |                     |  |           |                          |  |
|                          | -She did not know F  | ersonal care or showers.<br>Resident #5's care plan dated<br>mented extensive care for                   |                     |  |           |                          |  |

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|                          | OF CORRECTION   | IDENTIFICATION NUMBER:  | ` .                 | E CONSTRUCTION  |          | E SURVEY<br>PLETED       |
|--------------------------|---|---|---------------------|---|----------|--------------------------|
|                          |   | HAL060149   | B. WING             |   | 07/      | 29/2019                  |
| NAME OF                  | DROVIDED OD CURRUER   |   | DDEAG AIMA          |   | _   0172 | 23/2013                  |
| NAIVIE OF                | PROVIDER OR SUPPLIER  |   |                     | STATE, ZIP CODE   |          |                          |
| EAST TO                  | OWNE  |   | TTE, NC 282         | NAMITY ROAD<br>105  |          |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | ULD BE   | (X5)<br>COMPLETE<br>DATE |
| D 269                    | Continued From pa   | ge 22   | D 269               | ***   |          |                          |
|                          | #5] with showers ar -She did not know s daily shower assign #5 when they had not supervised Resider -The care plans should be appropriate care for the residents.  3. Review of Resider O1/16/19 revealed of disorder, chronic obconstipation, gastro hypertension, schizuse, and vasomotor | assist and supervise [Resident and toileting. Staff were documented on the ament log "Done" for Resident not assisted, seen or at #5 with her personal care, build be followed so we provide and services that are right ent #2's current FL-2 dated diagnoses included bipolar ostructive pulmonary disease, pesophageal reflux disease, oaffective disorder, tobacco in symptoms. |                     |   |          |                          |
|                          | the orthopedic doctor/124/19 at 11:20ar -Resident #2 under arthroplasty on 07/1-Resident #2 had a arranged by the hose-Resident #2 was worder was a door -Her right leg was subelow the knee and with a reddish area right ankle.  -A bandage was tap extended appropriat knee.             | went a total right knee 16/19. In normal discharge that was spital. Ireight bearing as tolerated. Ident #2 on 07/23/19 at In on a rolling walker by the holding an unlit cigarette. If wollen with a purplish bruising her right foot was dark purple below the knee and above the loved above the knee that tely 2 inches below the right  |                     |   |          |                          |
|                          | arthroplasty on 07/1 -Resident #2 had a arranged by the hos -Resident #2 was w  Observation of Res 10:15am observed: -Resident #2 sitting smoking area door -Her right leg was s below the knee and with a reddish area right ankleA bandage was tap extended appropriat knee.              | normal discharge that was spital. reight bearing as tolerated. ident #2 on 07/23/19 at on a rolling walker by the holding an unlit cigarette. wollen with a purplish bruising her right foot was dark purple below the knee and above the red above the knee that tely 2 inches below the blood   |                     |   |          |                          |

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 269 | Continued From page 23 D 269 Interview with Resident #2 on 07/23/19 at 10:15AM revealed: -Resident #2 had knee surgery last week on her right knee on 07/16/19. -She had trouble bearing weight on her right leg. -She stated that, "my led hurts like crap." -Resident #2 stated that the staff pushed her to the dining room in her rolling walker. Interview with Resident #2 on 07/29/19 at 10:45am revealed: -The facility staff did not assist her with showering or toileting. -She received a shower in the hospital "that's why I am clean now. -"I try to help myself, but it's hard to move around since I had my surgery.' -Every time I ring the call bell for assistance. "no staff would come to help me." -She had been wetting her diaper and sitting in urine until staff helped. -"My leg is swollen and hurts really bad." -No one at the facility had ever iced her knee for the swelling. -Staff told her she needed to sit down and elevate her right leg. -The doctor wanted her to move around and to try to walk. Review of Resident #2's care plan signed by the physician on 04/24/18 revealed: -Resident #2 required limited assistance with

since 04/24/19.

bathing, toileting, eating, and dressing.
-Resident #2 was independent with mobility.

Record review revealed no current care plan

Interview with the Lead Medication Aide on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                         | (X3) DATE SURVEY<br>COMPLETED  |       |                          |
|--|--|--|-------------------------|--|-------|--------------------------|
|  |  | HAL060149  | B. WING                 | <del></del>  | 07/2  | 9/2019                   |
| NAME OF  | NAME OF PROVIDER OR SUPPLIER STREET AI   |  |                         | TATE, ZIP CODE   |       |                          |
| EAST TOWNE   |  |  | TH SHARON<br>TE, NC 282 | I AMITY ROAD<br>05   |       |                          |
| (X4) ID<br>PREFIX<br>TAG   | (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |
| D 269  | 07/24/19 at 10:45ar-Resident #2 return surgery to her right-She thought Resid prior to returning the-Resident #2 return bearing as tolerated-Resident #2 was a knee surgery. She was not sure I Resident #2 required Interview with the factor on 07/24/19 at 11:4-He had not seen in the facility from hele was not aware swelling in her leg. Physical Therapy hele to her transfer some of the Resident resident needs clots and a stroke.  Review of the Resident is since her knee replect Resident is since her knee replect or reflect Resident in the swelling appearable. The swelling appearable in the swelling appearable i | m revealed: ed to the facility 24-hours after knee. ent #2 was going to rehable facility. ed to the facility as weight d. Imost total care since the now much assistance ed with toileting. ecility's Nurse Practitioner (NP) OAM revealed: tesident #2 since she returned having knee surgery. that Resident #2 was having had been ordered for Resident afely. ed to move to prevent blood dent #2's record on 07/24/19 and there was no documentation #2 was evaluated by the NP accement on 07/16/19. Eddent #2 on 07/25/19 at the in revealed: Fing in a hospital bed. Find the removed. Find the remov | D 269                   |  |       |                          |

Division of Health Service Regulation

FORM APPROVED Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 269 Continued From page 25 D 269 discharged. Interview with the hospital Medical Doctor (MD) on 07/25/19 at 10:30AM revealed: -Resident #2 would receive a physical therapy (PT) and occupational therapy (OT) evaluation. -Resident #2 needed assistance with her activities of daily living, toileting, and ambulation for safety and to prevent falls. -Resident #2 needed to move around to prevent a blood clot or stroke. Interview with another Lead Supervisor on 07/25/19 at 2:55pm revealed. -She was not aware of how much assistance Resident #2 required for her ADL's. -She had observed staff pushing her in her rolling walker with a seat. Interview with the RCC on 07/25/19 at 3:15PM and on 07/29/19 at 4:25PM revealed: -She had been the RCC for the facility since 07/08/19. -Resident #2 was receiving home health services for skilled nursing and physical therapy. -She was not sure how much assistance Resident #2 required for toileting, transfers. getting dressing, and ambulating in the facility. Confidential staff interview with on 07/29/19 revealed: -Resident #2 returned from having knee surgery and could not walk or change her pull up. -Resident #2 was total care with everything except eating. -Staff were never told how to care for Resident

Division of Health Service Regulation

#2's knee after surgery.

care for the knee.

-The RCD came to look at the resident's knee. but she never gave staff any direction on how to Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | l ' '                    | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|---|--|--|--------------------------|--|-------------------|--------------------------|
|   |  |  | , DOILDING.              |  |                   |                          |
| HAL060149   |  | HAL060149  | B. WING                  |  | 07/2              | 9/2019                   |
| NAME OF F   | PROVIDER OR SUPPLIER   |  |                          | STATE, ZIP CODE  |                   |                          |
| EAST TO   | WNE  |  | TH SHAROI<br>TTE, NC 282 | N AMITY ROAD<br>205  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES  |  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
| D 269   | Continued From paragraphs - Resident #2 could - Resident #2 was massist.  Confidential interview 07/29/19 revealed: - Resident #2 was conformated to a toileting, but the result in the paragraphs of the paragrap | barely get out of bed. ow requiring a 2-person  ew with an employee on onstantly ringing the call bell the weekend. assist Resident #2 with sident required a two person ading a second staff member now long it took to get with toileting Resident #2. ident #2 being soaked in urine sonal care. try to move around with a eeded staff assistance. icensed Health Professional jistered nurse, RN, on I revealed. ormed Resident #2 had t knee. vised staff on how to provide t's knee. leted an assessment on I to inform her of any changes ition so she could assess the proper care was being observation detail list report ed 07/17/19 revealed: as completed by the RCC on | D 269                    |  |                   |                          |
|   | 07/17/19 at 3:05pm<br>-The completion da<br>RCC was on 07/18/  | te of the observation by the   |                          |  |                   |                          |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE<br>COMP | B) DATE SURVEY<br>COMPLETED |  |
|---|---|--|--|--|-------------------|-----------------------------|--|
|   |   | HAL060149  | B. WING                                  |  | 07/2              | 9/2019                      |  |
| NAME OF   | PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, S                           | TATE, ZIP CODE   |                   |                             |  |
| FAST TOWNE  |   |  | TH SHARON<br>TE, NC 282                  | I AMITY ROAD<br>05   |                   |                             |  |
| (X4) ID<br>PREFIX<br>TAG                            | (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  |  | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE    |  |
| D 269   | -The RCC observed shin areaThe RCC observed -Discoloration was shin areaThere was no flaki -There was no reco -The RCC documed on the report, but the what the NP was no assessment of Res Telephone interview provider on 07/25/1 at 11:00am reveale -HH was initiated for edemaResident #2 receive health nursing on 00-Resident #2 report that the staff had not a the staff had not the home health provided with a physical staff of the physical staff had not a the staff had not the staff had no | d bruising on the left knee and do no scars. In left knee and any or pressure sores. In mended follow-up. Inted that she notified the NP lere was documentation on officed regarding her ident #2.  If with the home health 9 at 4:00pm and on 07/29/19 do: If Resident #2 on 07/11/19 for led her first visit from home 7/19/19. It is the physical therapist of done anything to help her. In let of the physical therapist of the physical therapist of the enviewed for further leveled: If the revealed: If the don't do anything for urting to bad to walk now." If oderate edema, letted to elevate her leg leg letted the cold pack could only be sician order. In that the physician will at the leg letted to the physician will at the leg letted to elevate will at the letted to elevate will at the leg letted to elevate will at the letted to elevate will at the leg le | D 269                                    |  |                   |                             |  |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER  (X1) PROVIDER/SUPPLIER  | n-n   ' '   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|--------------------------------|-------------------------------|--|
| HAL060149   | B. WING   |  | 07/2                           | 29/2019                       |  |
| NAME OF PROVIDER OR SUPPLIER  | STREET ADDRESS, CITY, ST  | TATE, ZIP CODE   |                                |                               |  |
| EAST TOWNE  | 4815 NORTH SHARON<br>CHARLOTTE, NC 2820   |  |                                |                               |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FI TAG REGULATORY OR LSC IDENTIFYING INFORMATI  | ID<br>ULL PREFIX  | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE      |  |
| required the resident to need much more encouragement to engage in the therapy.  Review of Resident #2's progress notes in The Resident Care Director, RCD, evaluate Resident #2 on 07/18/19 at 4:05pm.  The RCD documented bilateral extremitic swollen. The left greater than right based recent left knee replacement surgery.  Resident #2 was able to weight bear on mith a 2 person assist.  Resident #2 was using a rollator and not ambulating.  Resident #2 was sitting in the rollator mo around in the facility.  There was no documentation in the reconstaff to monitor or provide any additional of Resident #2.  Telephone interview with Resident #2's responsible party on 07/29/19 at 11:15am revealed:  She had taken Resident #2 to medical appointments because the facility would in transport, or the facility would get her to the appointment late.  Sometimes Resident #2 had body odor with going to appointments.  Resident #2 constantly called her to say staff would not assist her with showering of the bathroom.  She had talked with various staff member management that Resident #2 needed as and how staff would talk down to Resident -Since Resident #2 had the right knee sur 07/16/19, she felt Resident #2 needed to moved closer to the nurses' desk.  Resident #2 has told her that she wet he waiting on someone to take her to bathroor-Resident #2 informed her that when she | session. evealed: ated es were l on right leg  ving rd for care to  not ne when facility or going ers in esistance at #2. rgery on be r pants om. |  |                                |                               |  |

Division of Health Service Regulation

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 269 Continued From page 29 D 269 call bell nobody answered it. The facility failed to assure residents received necessary assistance with personal care as. evidenced by Resident #5 not receiving assistance with colostomy care resulting in the resident using paper towels to cover the stoma site which caused an odor of feces, leakage of feces onto the resident's clothes and onto the seat of the community transportation van, and embarrassment to the resident; Resident #5, who required extensive assistance with showers and bathing, not receiving assistance with showers or bathing which contributed to the resident having a foul odor of urine and feces, as well as a noticeable body odor; and Resident #2 who required assistance with personal care, toileting, transfers and ambulation after a recent knee replacement surgery not receiving assistance from facility staff. The facility's failure to provide the necessary assistance with personal care put Resident #5 at risk for skin breakdown around the stoma site, at risk for urinary infections due to uncleanliness, and continued embarrassment due to foul body odor, and put Resident #2 at risk for infection or a blood clot from non-mobility of the right lower extremity, as well as at risk for falls, after knee replacement surgery. These failures placed the residents at a substantial risk for physical harm and neglect which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 07/25/19 CORRECTION DATE FOR THE TYPE A2

2019.

Division of Health Service Regulation

VIOLATION SHALL NOT EXCEED AUGUST 26,

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 270 10A NCAC 13F .0901(b) Personal Care 10A NCAC 13F .0901(b) Personal Care and Supervision and Supervision 10A NCAC 13F .0901 Personal Care and Facility will ensure staff provide supervision Supervision of residents according to the residents 8/26/19 (b) Staff shall provide supervision of residents in assessed needs, care plan and current accordance with each resident's assessed needs. symptoms care plan and current symptoms. Facility has implemented Manager on Duty (MOD) program which consist of key 8/26/19 management team memebers, to include but not limited to the following: ED. DRC. RCC. Business Office Manager, Life Enrichment Cooridnator and Dietary Manager Manager on Duty will be scheduled to be on site during off business hours. This Rule is not met as evidenced by: Facility ED, RCC, DRC and/or other TYPE A2 VIOLATION management team members are completeing 8/26/19 facility rounds daily and doing "pop up" visits Based on observations, interviews, and record on different shifts to ensure supervision/safety reviews, the facility failed to assure supervision of residents. was provided to 2 of 7 sampled residents (Resident #12 and #13) related to a resident with Facility has implemented daily stand-up a history of substance abuse, found to have a 8/26/19 meetings with all department heads. Any knife, beer and marijuana in his room, who residents concerns will be addressed in returned to the facility on several occasions daily stand up meetings. intoxicated and smelling of marijuana, frequently intimidated staff and residents, threatening and Facility ED will issue immediate Transfer/ 8/26/19 assaulting another resident (Resident #13), and a Discharge Notice for any resident that puts resident who lived on the same hall as Resident the safety or health of other residents or individuals in the facility is in danger #13. in the back corner of the facility, who was threatened and assaulted by him, with no additional supervision provided for her safety by All staff have been in-serviced/trained on 8/20/19 & the staff (Resident #12). Managing Aggressive Resident. 8/22/19 1. Review of Resident #13's FL2 dated 01/17/19 revealed diagnoses included gastrointestinal hemorrhage, abdominal distension, gastroesophageal reflux disease, hypertension, muscle weakness, chronic obstructive pulmonary

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: |   |  | (X3) DATE :<br>COMPI    |  |                  |                          |
|---|---|--|-------------------------|--|------------------|--------------------------|
|   |   | HAL060149  | B. WING                 |  | 07/2             | 9/2019                   |
| NAME OF F   | PROVIDER OR SUPPLIER  |  | ORESS, CITY, S          | STATE, ZIP CODE  | •                |                          |
| EAST TO   | WNE   |  | TH SHARON<br>TE, NC 282 | I AMITY ROAD<br>05   |                  |                          |
| (X4) ID<br>PREFIX<br>TAG  | (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | .D BE            | (X5)<br>COMPLETE<br>DATE |
| D 270   | Continued From pa   | ge 31  | D 270                   | Continued from page 31   |                  | -                        |
|   | tobacco use, unsper prolapse, benign prolapse, benign properties.  Observation of Res 12:06pm revealed: -Resident #13 was towards the dining revealed:  | a, shortness of breath, cified psychosis, rectal ostatic hyperplasia, and ident #13 on 07/26/19 at walking down the hallway coming pushing a rolling on the seat, playing loud   |                         | Facility has implemented an incresupervision check form. Resident maybe placed on incresupervision for different reasons, include but are not limited to: * Behavioral issues * New Admissions * Fever or Illness * return from hospital or rehab st | ased<br>Reasons  | 8/26/19                  |
|   |   | ong musty, skunk-like odor<br>oe marijuana) on him.  |                         | RCC, DRC and or ED will determ residents are placed on increase supervision checks.  |                  | 8/26/19                  |
|   | 12:06pm revealed: -He felt that overall facilityThere was an incident   | things were good at the lent earlier in the week when lied on him and called the   |                         | RCC, DRC and/or ED will monitor increased supervision check form ensure completion of forms no le weekly while increased supervisiplace.   | ns to<br>ss than | 8/26/19                  |
|   | the incident, but eve   | od that he hated to laugh about<br>erything was so funny to him.<br>Hent #13, Resident #12 owed  |                         | Any resident placed on increased supervision will be discussed in castand up meetings.   |                  | 8/26/19                  |
|   | medication aide (M.   | onversation with his<br>A) when Resident #12 that<br>alled the "popo" on him.  |                         | RCC, DRC and/or ED will detem<br>a resident may be removed from<br>increased supervision checks.   |                  | 8/26/19                  |
|   | -He and the Reside she would pay him -He was not aware or doing illegal drug -He stated that it was anyone else does a -He was not aware facility for residents -He knows what mas am from Washingto -"What people do o | nt #12 had an agreement that back for buying her cigarettes. of residents smoking, drinking is in the smoking area. as none of his business what it the facility. of the police coming to the using drugs. arijuana smells like "because I |                         | All staff have been inserviced/trai<br>on increased supervision forms.   | ned              | 8/23/19                  |

| STATEMENT OF DEFICIENCIES (X<br>AND PLAN OF CORRECTION  |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                    | (X3) DATE SURVEY<br>COMPLETED |        |
|---|--|--|--|--------------------|-------------------------------|--------|
|   |  | HAL060149  | B. WING  |                    | 07/2                          | 9/2019 |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, 8   | STATE, ZIP CODE    |                               |        |
| FAST TOWNE  |  |  | TH SHARON  | NAMITY ROAD<br>105 |                               |        |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE               | (X5)<br>COMPLETE<br>DATE      |        |
| D 270   | Continued From pa  | ge 32  | D 270  |                    |                               |        |
| D 270   | smoke off propertyResident #3 stated facilityHe confirmed that morningHe would not confismoking or drinkingHe reported that somemory."  Observation of Res 2:30pm revealed: -Resident #13 was outside under a treeHe had headphone heardHe had a strong mappeared to be maistronger than earliedHe had a strong mappeared to be maistronger than earliedHe knew with Resident #13 requiredHe referenced the 07/26/19He knew the answer earlier that dayResident #13 state would be taken careHe would not acknow be taken care of.  Interview with the A 3:55pm revealed: -She was aware that believed he was up searched on 07/26/-She found a knife, | I he was never drunk in the he went off property this rm if he had engaged in that morning. Ometimes he had "selective dent #13 on 07/26/19 at sitting on a rolling walker by the road. So on, but music could still be usty, skunk-like odor (what rijuana smell) that was rethat afternoon. See a confidential interview. Interview from earlier on the questions from the dent #13 on 07/26/19 at the sted a couple days everything et. Owledge who or what would deministrator on 07/26/19 at at Resident #13 was upset and set when his room was 19. beer, and marijuana in | D 2/0  |                    |                               |        |
| . =   | room search.   | kpack on 07/26/19 during his   |  |                    |                               |        |

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING \_\_\_\_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 (XA) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|--|---------------------|---|--------------------------|
| D 270                    | Continued From page 33  -She planned to issue Resident #13 a discharge notice, but she had not at that timeShe was issuing the discharge notice once she had two male staff members present to serve as a witness.   | D 270               |   |                          |
|                          | Interview with a Lead Medication Aide on 07/26/19 at 4:26 pm revealed: -Resident #12 reported to the RCC, herself and the police that Resident #13 was threatening her every time she would go out to the smoking areaResident #13 had told the Resident #12 not to talk because he did not want to hear her voiceNeither Resident #12 or Resident #13 wanted to move roomsShe never documented that either resident was offered a room changeShe never informed staff on what to do or document when Resident #13 was exhibiting behaviorsShe had observed Resident #13 bringing beer into the facility last weekShe never smelled marijuana on Resident #13She thought Resident #13's primary care physician, (PCP), was aware of Resident #13's behaviors and drinkingShe had never informed the PCPResident #13 had an incident where he fell out in the hallway smelling of alcohol when he had stayed out all nightResident #13 was involuntarily committed (IVC) after that incident. |                     |   |                          |
|                          | Interview with a resident in the facility on 07/29/19 at 10:45am revealed: -She was outside in the smoking area when the police were called on Resident #13Resident #13 was drinking beer and smoking pot outside in the smoking areaShe was smoking cigarettes because "she did   |                     |   |                          |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION  | (X3) DATE SURVE<br>COMPLETED |                          |
|---|--|--|---------------------|---|------------------------------|--------------------------|
|   |  | HAL060149  | B. WING             |   | 07/5                         | 29/2019                  |
| NAME OF   | PROVIDER OR SUPPLIER   |  | DRESS, CITY, S      | STATE, ZIP CODE   |                              |                          |
| CHARLO  |  |  | TH SHAROI           | N AMITY ROAD<br>205   |                              |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | IOULD BE                     | (X5)<br>COMPLETE<br>DATE |
| D 270   | not like the way pot not like the taste of -Resident #13 was eveningResident always excursed, "gets in permusicStaff was aware of everyone just allow whatever he wanter-she thought staff vor Telephone interview party on 07/29/19 a -She had taken car approximately 17 ye -She had never known arijuana or drink to -She did not like the Resident #13Staff had informed hanging around Re -Staff informed her of Resident #13's b -Management woul go out and do his own thin -No matter what time evenings and on we be in the smoking a -"It felt like manage how many times shin the building."  Confidential interview 07/29/19 revealed: -Resident #13 did management. | makes her feel and she did beer." talking "a lot of trash" that khibited behaviors where he ople faces", and plays loud Resident #13's behaviors, but ed Resident #13 to do do to do. vas afraid of him.  with a resident's responsible to 11:15am revealed: e of the resident for ears. why the resident to smoke oper. e resident being around her that the resident was sident #13 who "smokes pot." that management was aware ehaviors. d just allow "Resident #13 to wn thing." not elaborate on what "go out | D 270               |   |                              |                          |

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ' '                 | E CONSTRUCTION   | (X3) DATE | SURVEY<br>PLETED         |
|---|---|--|---------------------|--|-----------|--------------------------|
| THE TENTO CONNECTION                                |   |  | A, BUILDING:        | <u> </u>   |           |                          |
| HAL060149   |   | B. WING  |                     | 07/2   | 9/2019    |                          |
| NAMEOF  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |           |                          |
| EAST TO   | CHARLO  |  |                     | N AMITY ROAD<br>205  |           |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE     | (X5)<br>COMPLETE<br>DATE |
| D 270   | and drinking beer in-Resident #13 would buildingResident #13 would anything to me becaresident #13 was and other residentsHe displayed his agarguing with staff and residentsThe issue was told never did anything a behaviorsResident #13 alwar would refuse to turn.  Review of facility not for Resident #13 alwar would refuse to turn.  Review of facility not for Resident #13 was coloud music and usin RCC was able to reproblemThe MA documentation and confise resident #13 and confise room and confise explained to Resident to responsible to the importance of the consumption with the Refer to confidential visitor on 07/25/19 and to the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the Refer to confidential visitor on 07/25/19 and the resident with the re | a the outside smoking area. In the outside smoke in the disample of sometimes smoke in the disample of say "they are not going to do ause I am grown." always aggressive with staff of ggressive behaviors by and residents. In a habit of threatening to hit to the previous ED, but he about Resident #13's are played very loud music and an the music down.  In the music down.  In the following of the following of the previous the following of the foll | D 270               |  |           |                          |
|   | Refer to interview w  | rith the Administrator on  |                     |  |           |                          |

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 270 Continued From page 36 D 270 07/25/19 at 4:30pm. Refer to confidential interview with a resident. Refer to confidential staff interview. 2. Review of Resident #12's FL2 dated 01/17/19 revealed: -Diagnoses included cerebral infarction, pulmonary disease, cerebral aneurysm, hypertension and depression. -Resident #12 was semi-ambulatory with a wheelchair. Interview with Resident #12 on 07/25/19 at 9:00 am revealed: -On 07/23/19 at dinner time, Resident #13 approached Resident #12 at her dining table and said he was on the verge of killing her. -Between 7:00pm and 8:00pm that same evening Resident #12 was in the smoking area of the facility with 2 other women. -In the adjacent screened in porch area. connected to the smoking area, Resident #13 was drinking alcohol and smoking marijuana. -Resident #13 came out from the porch and raised his fist as he approached Resident #12 yelling, "Shut up and go away-you annoy me!" -Resident #12 called the police to report Resident

Division of Health Service Regulation

#13's threats toward her.

want to hear your voice!".

did not have private transportation.

-The Administrator was in the building at the time and stated she would have the staff "watch him." -About one month ago, Resident #13 hit Resident #12 in the back of the head as she was wheeling herself from the smoking area, yelling "I just don't

-Resident #12 reported the assault to the police.
-Resident #12 did not press charges at that time because the previous Executive Administrator told her she would have to go to court, and she

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | , <i>,</i>   | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |       |                          |
|---|---|--|---------------------|--|-------|--------------------------|
|   |   | HAL060149  | B. WING             |  | 07/2  | 9/2019                   |
| NAME OF   | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | TATE, ZIP CODE   |       |                          |
| EAST TO   | OWNE  |  | TH SHARON           | I AMITY ROAD<br>05   |       |                          |
| (X4) ID<br>PREFIX<br>TAG  |   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU)<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |
| D 270   | -'I could not inconve a family and works -Resident #12 sleep hand" and will "knot (Resident #13), con-Resident #12 think on with me. He is a snap some day."  Refer to confidentiat visitor on 07/25/19 at 4:30pm  Refer to confidentiat telephoromy.  -Visitor came to the police because a staff.  -Visitor did not with Resident #13 was a sand staff.  -Visitor described as and staff.  -Visitor described as staff. | enience my daughter who has full-time."  It is with her cane in her "good ock his head off if he, nes near me."  Is he (Resident #13) will " keep ticking time bomb and will telephone interview with a at 3:45pm.  If the Administrator on  If staff interview.  If interview with a resident.  In a facility to visit a resident on evening meal. commotion going in the at a worker had called the aff person was hit by Resident ess the incident but stated that always in the smoking area where the smell from the area | D 270               | DETICIENCY   |       |                          |
|   |   | a threatening manner."   |                     |  |       |                          |

Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ' '  | E CONSTRUCTION            | (X3) DATE SURVEY<br>COMPLETED   |            |                          |
|---|--|--|---------------------------|---|------------|--------------------------|
| 71101011  | or connection  | IDEITH ION HOMBER.   | A. BUILDING:              | <del></del>   | COMPLETED  |                          |
|   |  | HAL060149  | B. WING                   |   | 07/29/2019 |                          |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S            | STATE, ZIP CODE   |            |                          |
| EAST TO   | OWNE   |  | RTH SHARON<br>FTE, NC 282 | N AMITY ROAD  |            |                          |
|   | OLIMAN DV OTA  |  |                           |   |            | 1                        |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE      | (X5)<br>COMPLETE<br>DATE |
| D 270   | Continued From page 38   |  | D 270                     |   |            |                          |
|   | 4:30pm revealed: -She confirmed the Resident #13 gettin with Resident #12 of (07/23/19)The Administrator and two other male resident were in the alcohol and smokin -Resident #12 calle #13 had verbally the -The Administrator place to ensure Resident #13The Administrator was threatened, an same hall just doors  Confidential staff in -Resident #13 intim residentsHe was loud and a -He obtained drugs facility at a "drug ho facility "high" and so  Confidential intervice -She was in the sm -She witnessed Resident -Resident #13 threa the police arrivedA few months ago, by Resident #13 as areaThe staff and the re- | In the police because Resident reatened her. In the police because Resident reatened her. In the police because Resident reatened her. In the police is a part from each other. It is a part from the part |                           |   |            |                          |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPL<br>A. BUILDING:  | E CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED   |                         |                          |
|--|--|---|----------------|---|-------------------------|--------------------------|
|  |  | HAL060149   | B. WING        |   | 07/29/2019              |                          |
| NAME OF I  | PROVIDER OR SUPPLIER   | 4815 NOR  |                | STATE, ZIP CODE<br>N AMITY ROAD   |                         |                          |
| (X4) ID<br>PREFIX<br>TAG   | REFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX   |   |                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY)   | D BE                    | (X5)<br>COMPLETE<br>DATE |
| D 270  | drugs" in the screen  The facility failed to for 2 of 7 sampled r supervision of Residual have substance about intoxicated at the facility and assaulting a female Resident #12 who wought in her room for #13 who had threat with whom she had The facility's failure and protect them from the facility is failure and protect them from the facility is failure and protect them from the facility provided accordance with G. this violation.  CORRECTION DATES. | ned in area.  provide adequate supervision  | D 270          |   |                         |                          |
| D 271  | Supervision  10A NCAC 13F .09  Supervision (c) Staff shall response an accident or incident  | 01(c) Personal Care and 01 Personal Care and ond immediately in the case of ent involving a resident to tervention according to the d procedures. | D 271          | 10A NCAC 13F .0901(c) Personal Ca Supervision  Facility will ensure staff respond immethe case of an accident or incident invresident to provide care and interventi according to the facilities policies and procedures. | ediately in<br>olving a | 8/26/19                  |

Division of Health Service Regulation

|                          | of Health Service F  |  | 1   |  | 7                             |                          |
|--------------------------|--|--|---|--|-------------------------------|--------------------------|
|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|                          |  |  | 7 4 501251113   | , <u> </u>   | 1                             |                          |
|                          |  | HAL060149  | B. WING   |  | 07/2                          | 9/2019                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREETAL   | ODRESS, CITY,   | STATE, ZIP CODE  |                               |                          |
| EAST TO                  | WNE  |  |   | N AMITY ROAD   |                               |                          |
|                          |  |  | TTE, NC 28  |  | 1110                          |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)               | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)                                       | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| D 271                    | Continued From p   | age 40   | D 271   | Continued from page 40   | -                             |                          |
|                          | This Rule is not met as evidenced by: TYPE A2 VIOLATION  |  |   | Facility has implemented "Who an what I need" forms which are kept binder at nurses desk and readly a all staff.                                 | in a<br>available fo          |                          |
|                          | Based on record reviews and interviews, the facility failed to respond to incidents immediately                                    |  | "Who am I" forms reflect residents personal care including code statu | needs wit<br>ie.   | h<br>8/26/19                  |                          |
|                          | and in accordance  | nd in accordance with the facility's established plicy and procedures for one resident sampled |   | "Who am I" forms shall be updated<br>a change in code status for reside  |                               | 8/26/19                  |
|                          | Review of Resident #9's current FL2 dated 02/07/19 revealed diagnoses included dementia, diabetes, cerebral vascular accident, and |  |   | Any new admissions to facility will<br>am I" form completed at admission<br>All facility staff have been trained/i<br>on "Who am I" forms/binder | 1                             | 8/26/19                  |
|                          | electronic Medicat   | nt #9's facesheetand the<br>ion Administration Record<br>she was a full code.                  |   | Facility has completed an audit of face sheets, charts and emars to all reflect residents current/correct  | ensure                        | 8/26/19<br>Is            |
|                          | Interview with the A   | Administrator on 07/26/19 at   |   | Facility has implemented "pink" do for all residents who have a DNR i  |                               | 8/26/19                  |
| :                        | -The facility policy resident is to initiate code.   | for finding an unresponsive te CPR if the resident is a full ontinued until EMS arrived to     |   | All residents who have a DNR in p<br>have a Pink Dot on the name plate<br>their name outside of room.  |                               | 8/26/19                  |
|                          | take over or prono   |  |   | Should resident code status chang<br>facility ED, RCC,DRC and/or Desi-<br>ensure all forms, emars and Pink I                                     | gnee will                     | 8/26/19<br>1             |
|                          | Resident #9 dated  | ent #9 dated 06/25/19 at 10:03pm revealed:<br>tion of incident was in the resident's           |   | is updated  All Facility staff have been trained   | ·                             | ٦                        |
|                          | -The incident was<br>-Type of injury was<br>noted.   | documented as no injury  |   | on "Pink" Dot system   |                               | 8/26/19                  |
|                          | "medics".  | umented as administered by n was unresponsive; "resident                                       |   |  |                               |                          |

Division of Health Service Regulation STATE FORM

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                     |  | (X3) DATE SURVEY<br>COMPLETED |                          |  |
|---|---|--|---------------------|--|-------------------------------|--------------------------|--|
|   |   |  | A, BUILDING         | ·  |                               |                          |  |
|   |   | HAL060149  | 8. WING             |  | 07/2                          | 9/2019                   |  |
| NAME OF   | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY,        | STATE, ZIP CODE  |                               |                          |  |
| EAST TO   | )WNE  |  | TH SHARO            | N AMITY ROAD   |                               |                          |  |
| WAY ID  | SUMMARY STA   | TEMENT OF DEFICIENCIES   |                     | PROVIDER'S PLAN OF CORRECTION  | NAI .                         | 1025                     |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY)   | D BE                          | (X5)<br>COMPLETE<br>DATE |  |
| D 271   |   | ge 41  | D 271               | Continued from page 41   |                               |                          |  |
|   | has expired".  -The physician and the family were notified.  -There was no documentation Cardiopulmonary Resuscitation CPR was initiated by the facility staff.  Review of Resident #9's electronic progress notes dated 06/24/19 at 5:15am revealed:  -"Resident passed away in the bathroom."  -There was no other documentation.  -There was no documentation CPR was performed per the facility policy.  Review of the Emergency Medical Service (EMS) report for Resident #9 dated 06/24/19 revealed:  -The facility called EMS at 5:26am. |  |                     | Facility staff have been trained why and whe CPR is Initiated. Training provided by Licensed RN  |                               | 7/29/19                  |  |
|   |   |  |                     | Facility staff have received training Facility Policies and Procedures   | on                            | 8/20/19 &<br>8/22/19     |  |
|   |   |  |                     | Facility has provide CPR Training to<br>additional staff members.<br>Facility has schedule additional CP<br>Training for September 16,2019 |                               | 7/31/19                  |  |
|   |   |  |                     | Facility RCC and/or ED will ensure that there is no less than one staff per shift who is CPR Certif  |                               | 8/26/19                  |  |
|   | -The unit was dispa<br>and arrived at the fa<br>-At 5:33am the EMS<br>documented the foll   | tched to the facility at 5:27am<br>acility at 5:31am.<br>5 crew arrived at patient and<br>lowing:  |                     | Facility staff have been trained on page documentation and reporting.  |                               | 8/23/19                  |  |
|   |   | o ALS for cardiac arrest."<br>7 year old is found lying supine<br>or."   |                     | Facility staff have received training accident and incident reporting.   | on                            | 8/26/19                  |  |
|   | pupils, showing no s -"The patient has dr and on her shirt." -"Noted rigor mortis upper and lower ext -"EKG showed asys palpated, all reading -"Onset is unknown"Staff were unable alive." -"DNR status is unk -"EMS was only give -"The patient found is unknown."   | ried vomit around her mouth of the jaw as well as both tremities." stole, no mechanical pulse is gs are zero." ." to state when patient was last nown." en a face sheet." by her roommate but the time |                     |  |                               |                          |  |
|   | Telephone interview   | with the Lead Crew Medic on  |                     |  |                               |                          |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |            |                          |
|--|--|--|---------------------|--|------------|--------------------------|
|  |  | HAL060149  | B. WING             |  | 07/29/2019 |                          |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |            |                          |
| EAST TO  | OWNE   |  | TH SHARON           | N AMITY ROAD<br>205  |            |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE      | (X5)<br>COMPLETE<br>DATE |
| D 271  | 07/29/19 at 3:30pm -He was dispatched of 06/24/19 for Res -He found Resident floor near the toilet -There were no facilibathroom and no or -EMS did not do CF -"There was dried word was found the toilet of the toi | revealed: It to the facility on the morning ident #9. #9 laying on the bathroom on her back. lity staff present in the ne performing CPR. PR. It comit around the patient's It available to report Resident for report the cause or the time  be present he would guess alonger 3-4 hours. Inmate answered most of the nutes just to get Resident #9's staff."  If with Resident #9's Physician pm revealed; It im aware Resident had It im aware Resident had It im aware Resident had It im aware the sident had It is in the jaw upper extremities, she must in the floor for 3-4 hours or  If with the third shift Medication It is in the sident #9 It is in t | D 271               |  |            |                          |

Division of Health Service Regulation

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 271 Continued From page 43 D 271 Stick Blood Sugar when she found Resident #9 laying on her back on the bathroom floor. -She called 911 and started CPR on Resident #9. -She did a finger sweep to clean Resident #9's mouth out, then did mouth to mouth and chest compressions. -"When EMS arrived, they took over CPR". -The policy was when a resident is a full code you do CPR until EMS arrives in the facility to take over CPR. -Resident #9 was a full code. -She had documented in the computer system at 5:15am "Resident passed away in the bathroom." Interview with a resident in the facility on 07/26/19 at 6:06pm revealed: -She had gone into the bathroom on 06/24/19 around 5:00am and found Resident #9 laying on the bathroom floor near the toilet. -Resident #9 was laying on her back. -She went to find help and found the MA near the dining room hallway. -The MA came into the bathroom and said, "she is dead". -The MA closed Resident #9 eyes, "I did not see her do CPR." -The MA told another staff to call 911. -Resident #9 was left in the bathroom for a long time. -EMS arrived and the resident thought they were going to take Resident #9, but they did not.

Division of Health Service Regulation

at 11:00pm to 06/24/19 at 7:00am.

Telephone interview with a Personal Care Aide (PCA) on 07/26/19 at 7:20pm revealed: -She had worked a week at the facility prior to

-There were 3 staff working third shift on 06/23/19

-She had worked on third shift when Resident #9 was found unresponsive on the bathroom floor.

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1 ' '               | E CONSTRUCTION   | (X3) DATE |                          |  |
|--------------------------|---|--|---------------------|--|-----------|--------------------------|--|
| ANDFLAN                  | OF CORRECTION   | IDENTIFICATION NUMBER.   | A. BUILDING:        | <u> </u>   | COMPLETED |                          |  |
|                          |   | HAL060149  | B. WING             |  | 07/2      | 07/29/2019               |  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |           |                          |  |
| EAST TO                  | W/NF  | 4815 NOR   | TH SHARO            | N AMITY ROAD   |           |                          |  |
| LAOI 10                  | , , , , , , , , , , , , , , , , , , ,   | CHARLOT  | TTE, NC 282         | 205  |           |                          |  |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE     | (X5)<br>COMPLETE<br>DATE |  |
| D 271                    | Continued From pa   | ge 44  | D 271               |  |           |                          |  |
| D 271                    | -A resident had four around 5:00am on 6-She was not sure of Resident #9 that me-She remembered of around 12:00am and The MA who had we perform CPR on Resident #9 characteristics of the PCA had perform CPR on Resident when.  -The PCA had perform the PCA had perform CPR on Resident when.  -The MA called 911 MA called 911 MA called.  Telephone interview 07/27/19 at 10:20ard She had worked the Resident #9 was for bathroom.  -There were 3 staff at 11:00pm to 06/24 she was assigned hallway, she did not assignment.  -She was assigned hallway, she did not assignment.  -She went into the key laying on the bather back.  -The MA was stand 911.  -She was unsure we was.  -She never saw the #9. | nd Resident #9 unresponsive 06/24/19. what had happened to orning. checking on Resident #9 and at 3:00am. worked on 06/24/19 did not esident #9 orned CPR on Resident #9 oressions. and CPR training, but could not , she was not sure when the with another PCA on m revealed: aird shift on 06/24/19 when und unresponsive in the working third shift on 06/23/19 at 7:00am. To the other side of the thave Resident #9 in her er PCA yell "she is dead, she is pathroom and saw Resident throom floor near the toilet on ing over Resident #9 calling that Resident #9's code status MA initiate CPR for Resident A shake [Resident #9] to see if | D 271               |  |           |                          |  |
|                          | -She did see the M/<br>she would wake up  |  | •                   |  |           |                          |  |

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ HAL060149 B. WING 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) D 271 Continued From page 45 D 271 MA on 07/29/19 at 3:15pm revealed: -She did not initiate CPR for Resident #9 on 06/24/19, the PCA started CPR. -She was unable to physically get down on the floor to initiate CPR, and the PCA could. -She did not know if the PCA had a current CPR or if she been trained in CPR. -The PCA only did chest compressions, she was unsure for how long. -She was unsure if the PCA continued chest compression until EMS arrived, she did not stay in the room with Resident #9. -She could not say why at 5:15am she had documented in the progress notes Resident #9 had passed away, and EMS was not called until 5:26am. -She documented Resident #9 had died at 5:15am on 06/24/19 without conformation of death from a licensed medical professional, a physician or the EMS crew. -She had not listened through a stethoscope for a heartbeat or checked for a pulse to determine condition of Resident #9. Interview with a PCA on 07/25/19 at 8:43am revealed: -She had worked first shift on 06/24/19 when Resident #5 was found unresponsive on the bathroom floor. -"I think she choked on something." -"She was on a pureed diet but would get crackers out of the vending machine.' -"She had to be watched all the time." -"She was not sick the day before, I am not sure what happened." Interview with a second MA on 07/25/19 at 9:30am revealed:

Division of Health Service Regulation

-She was not working the morning of 06/24/19 when Resident #9 was found unresponsive on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |            |                          |
|--|--|--|---------------------|--|------------|--------------------------|
|  | HAL060149  |  | B. WING             |  | 07/29/2019 |                          |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |            |                          |
| EAST TO  | FAST TOWNE   |  |                     | NAMITY ROAD  |            |                          |
|  |  |  | TE, NC 282          | ······································   |            |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE      | (X5)<br>COMPLETE<br>DATE |
| D 271  | Continued From pa<br>the bathroom floor.   | -  | D 271               |  |            |                          |
| l  | -The facility policy was if a resident was a full code we were to do CPR until EMS arrived and took overResident #9 was a full codeResident #9 was on a pureed diet but other residents would give her crackers and oatmeal cookiesIf Resident #9 had money she would go to the vending machine and buy snacks.  Interview with a third MA on 07/25/19 at 2:15pm revealed: |  |                     |  |            |                          |
|  |  |  |                     |  |            |                          |
|  |  |  |                     |  |            |                          |
|  |  |  |                     |  |            |                          |
|  |  | vas to start CPR if the resident continue CPR until EMS er.                          |                     |  |            |                          |
|  |  | chest compressions.<br>e "plastic mouth shields" to<br>nouth.                        |                     |  |            |                          |
|  | Observation with the RCC present in the medication room in the top cabinet on 07/25/19 at 2:27pm revealed there were approximately 20 barrier devices to use for performing mouth to mouth resuscitation.  |  |                     |  |            |                          |
|  | (RCC) on 07/25/19<br>-She had worked in  | esident Care Coordinator<br>at 2:25pm revealed:<br>the facility for 3 weeks as the   |                     |  |            |                          |
|  |  | aff were to initiate CPR which   |                     |  |            |                          |
|  | until EMS or license   | pressions and mouth to mouth<br>ed personal arrived.<br>hat had happened on 06/24/19 |                     |  |            |                          |
|  | when Resident #9 v<br>floor unresponsive.  | vas found on the bathroom  |                     |  |            |                          |
|  | happened, the time   | umentation in regard to what it happened, or if CPR was dent #9 on 06/24/19.         |                     |  |            |                          |

|                   | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:         | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | COMPLETED |                  |
|-------------------|--|---|---|--|-----------|------------------|
|                   |  | HAL060149   | B. WING                                 |  | 07/2      | 9/2019           |
| NAME OF I         | PROVIDER OR SUPPLIER   |   | DRESS CITY S                            | STATE, ZIP CODE                              |           |                  |
| NAME OF I         | -KOVIDEK OK SUFFLIEK   |   |   | I AMITY ROAD                                 |           |                  |
| EAST TO           | WNE  |   | TE, NC 282                              |  |           |                  |
| (X4) ID<br>PREFIX |  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL              | ID<br>PREFIX                            | PROVIDER'S PLAN OF CORRECTI                  |           | (X5)<br>COMPLETE |
| TAG               |  | SC IDENTIFYING INFORMATION)                                   | TAG                                     | CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | PRIATE    | DATE             |
| D 271             | Continued From pa  | ge 47   | D 271                                   |  |           |                  |
|                   | -The lead MA had o<br>on 06/24/19.   | completed the incident report                                 |   |  |           |                  |
|                   | revealed:  | ead MA on 07/25/19 at 3:00pm                                  |   |  |           |                  |
|                   | not arrive a the faci  |   |   |  |           |                  |
|                   | <ul> <li>Her responsibilities</li> <li>MAs and the PCAs</li> </ul>                             | s included over-seeing the                                    |   |  |           |                  |
|                   | -She had completed the incident report on 06/24/19 per the former Administrator's advice.      |   |   |  |           |                  |
|                   | -She had spoken to the staff briefly that worked on 06/24/19 when resident #9 was found on the |   |   |  |           |                  |
|                   | floor unresponsive.  | the progress note written at                                  |   |  |           |                  |
|                   |  | 9 by the MA who worked that                                   |   |  |           | ·                |
|                   |  | MA performed CPR but then                                     |   |  |           |                  |
|                   | -She was unsure if   | anyone performed CPR  |   |  |           |                  |
|                   |  | was if a resident was found                                   |   |  |           |                  |
|                   | unresponsive the since EMS arrived.  | taff are to initiate CPR until                                |   |  |           |                  |
|                   |  | what happened or did not<br>n 06/24/19 because there was      |   |  |           |                  |
|                   | no documentation.  |   |   |  |           |                  |
|                   | Interview with the A<br>11:45am revealed:  | dministrator on 07/26/19 at                                   |   |  |           |                  |
|                   | -She had worked in   | the facility since July 1, 2019.                              |   |  |           |                  |
|                   | was to initiate CPR  | or an unresponsive resident<br>until EMS arrived to take over |   |  |           |                  |
|                   | CPR, or pronounce<br>-She did not know t   | e dead.<br>the MA had not performed                           |   |  |           |                  |
|                   | CPR on resident #9   |   |   |  |           |                  |
|                   | had documented in  | the electronic progress note                                  |   |  |           |                  |
|                   |  | way in the bathroom."<br>EMS was not contacted until          |   |  |           |                  |

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ B. WING \_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) D 271 Continued From page 48 D 271 5:26am on 06/24/19. -She relied on her lead MA to complete and review the incident reports. -She relied on her clinical staff to follow the policies of the facility. Review on 07/25/19 of the death certificate for Resident #9 located in the facility revealed the document was incomplete; there was no cause of death documented or no medical director / physician's signature on the death certificate. The facility failed to respond immediately in accordance with the facility's policy and procedures for assuring CPR was attempted for Resident #9 who was found unresponsive on the floor and was a "full code." The facility's policy was to perform cardio-pulmonary resuscitation (CPR) whenever a resident was found unresponsive, without a pulse, and/or not breathing until EMS arrives, however, staff failed to perform CPR for Resident #9 after she was found on the bathroom floor unresponsive and without a pulse. The facility's failure to respond immediately in accordance with its policies and procedures in the event of an unresponsive resident, places residents at substantial risk of neglect, physical harm or death which constitutes a Type A2 violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 07/25/19, **CORRECTION DATE FOR THE TYPE A2** 

Division of Health Service Regulation

2019.

VIOLATION SHALL NOT EXCEED AUGUST 26.

D 273 10A NCAC 13F .0902(b) Health Care

D 273

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|---|--|---|---|-------------------------------|--------------------------|
|                          |   | HAL060149  | B. WING                                 |   | 07/29/2019                    |                          |
| NAME OF I                | PROVIDER OR SUPPLIER  | 4815 NOR   |   | STATE, ZIP CODE<br>N AMITY ROAD<br>105  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   |                               | (X5)<br>COMPLETE<br>DATE |
| D 273                    | Continued From page 49  10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. |  | D 273                                   | 10A NCAC 13F .0902 (b) Health C   | are                           |                          |
| !                        |   |  |   | Facility will assure that referral and is provided to meet the routine and health care needs of residents.  |                               | 8/26/19                  |
|                          |   |  |   | Facility has adjusted the responsit managing appointments and follow  |                               | 8/26/19                  |
|                          |   |  |   | Facility RCC, DRC and/or Transpo<br>designee will follow up on all appo   |                               | 8/26/19                  |
|                          | This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION  Based on these findings, the previous Type A1   |  |   | Facility ED, RCC and/or DRC will<br>appointment book for all appointm<br>scheduled for the following day ar<br>communicate to staff upcoming<br>appointment               | nents                         | 8/26/19                  |
|                          |   | pated.<br>lons, interviews and record<br>failed to assure healthcare   |   | Facility has implemented daily sta<br>with all department heads. Appoir<br>Transportation is discussed in me  | ntments/                      | 8/26/19                  |
|                          | referral and follow-t<br>for 4 of 7 sampled to<br>following up with a<br>consult after a hosp   | up to meet the medical needs<br>residents related to not<br>cardiology and pulmonology<br>bitalization for chest pain  |   | Facility ED, RCC, DRC and/or Dewill document in resident progress any healthcare referral/follow-up.  |                               | 8/26/19                  |
|                          | missed appointmer<br>an endocrinology contifying the physic   | notifying the physician of a<br>nt and delayed rescheduling of<br>onsult (Resident #3), and not<br>ian of 3 missed colonoscopy<br>yo residents (Residents #1 and |   | Facility ED, RCC, DRC will monity resident progress notes for any rewho have had scheduleld appoint weekly times one month, then rare thereafter to ensure documentation. | esident<br>Iments<br>Idomly   | 8/26/19                  |
|                          | 01/16/19 revealed of<br>chronic obstructive<br>constipation, gastro   | ent #2's current FL-2 dated<br>diagnoses of bipolar disorder,<br>pulmonary disease,<br>pesophageal reflux disease,<br>coaffective disorder, tobacco              |   | Facility ED, RCC, DRC and/or Des<br>will ensure any missed appointment<br>follow-ups are immediately<br>rescheduled and residents PCP with<br>be notified.                | nts and/or                    | 8/26/19                  |
|                          |   |  |   |   |                               |                          |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                             | ' '                 | E CONSTRUCTION  | (X3) DATE<br>COMP |                          |
|--------------------------|---|---|---------------------|---|-------------------|--------------------------|
| ANDIBAN                  | OF CONTRECTION  | BERTH IS THE NEW BEIN   | A. BUILDING:        | Building:   |                   | -L:LD                    |
|                          |   | HAL060149   | B. WING             |   | 07/29/2019        |                          |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET ADI  | ORESS, CITY, S      | STATE, ZIP CODE   |                   |                          |
| EAST TO                  | WNE   |   |                     | N AMITY ROAD  |                   |                          |
|                          | OUR BLANDS / OTA  |   | TE, NC 282          | ·   | 511               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)                                    | D BE              | (X5)<br>COMPLETE<br>DATE |
| D 273                    | Continued From page 50  |   | D 273               | Continued from pag 50   |                   |                          |
|                          | 01/09/19 revealed: -Resident #2 was s chest pain.   | #2's hospital discharge dated ent to the emergency room for CT angiogram that was |                     | Facility will ensure that residents, s<br>residents Primary Care Physician (<br>are notified of any missed appointr<br>follow-up            | PCP)              | 8/26/19                  |
|                          | negative, but she continued to complain of a dull chest pain.  -Her COPD was exacerbated.  -Discharge plan was to follow-up the pulmonologist to become an established patient.  Review of Resident #2's hospital discharge summary dated 07/28/19 revealed:  -Resident #2 was sent to the emergency room for chest pain.  -She received ultrasound of her right lower extremity for possible blood clots that was negative.  -No further evaluation was indicated. |   |                     | Facility ED, RCC, DRC and/or Des will document in resident progress missed appointments/follow-up and notification to residents PCP.        | notes             | 8/26/19                  |
|                          |   |   |                     | Facility has implemented a "purple system. Transportion driver will tak folder to appointments.   |                   | 8/26/19                  |
|                          |   |   |                     | Transportation will return from app<br>with purple folder and give to RCC<br>and/or ED for review and ensure for<br>is complete             | ,DRC,             | 8/26/19                  |
|                          | summary dated 07/<br>-Resident #2 was s   | een in the emergency room   |                     | Facility transportation staff have be<br>in-serviced on the importance of as<br>residents appointments are comple<br>"purple folder" system | ssuring           | 8/26/19                  |
|                          | ·   | ng shortness of breath. #2's hospital discharge dated                             |                     | Facility staff have been trained<br>on Resident Prep Status for Surge<br>or treatment and "NPO" by a Licen<br>RN                            |                   | 8/23/19                  |
|                          | -Resident #2 seen i<br>pain in central area<br>in the facility lifted h<br>-She had shortness   |   |                     | Facility staff have been trained on when and how to document and the importance of documentation by E Licensed RN                           |                   | 8/23/19                  |
|                          | of the right lower ex-<br>-There was no evid<br>Thrombosis.<br>-A recommendation<br>with orthopedic doc<br>appointment and wi   | tremities.  |                     | Facility staff have been trained on<br>Health Care Referral and Follow-up<br>ED and a Licensed RN   | p by              | 8/23/19                  |
|                          | one day.  |   |                     |   |                   |                          |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|---|--|-------------------------------|--------------------------|
|   | HAL060149  | B. WING                                 |  | 07/2                          | 9/2019                   |
| NAME OF PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, S                          | STATE, ZIP CODE  |                               |                          |
| EAST TOWNE  |  | TH SHARON<br>TE, NC 282                 | NAMITY ROAD<br>105   |                               |                          |
| PREFIX (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                               | (X5)<br>COMPLETE<br>DATE |
| D 273 Continued From pa   | Continued From page 51   |   |  |                               |                          |
| Review of Residen 06/25/19 revealed: -Resident #2 was sichest pain for 2-dar-She complained or chest wall tenderne. The discharge plant cardiologist for the Review of Resident summary dated 05Resident #2 was sof chest pain for 2-She reported the prothing is making the reported the prothing is making the resident #2's worlessedent #2's worlessedent #2 started 10:00AM today, prother studies were well-there was no followed to the prothing is making the resident #2 started 10:00AM today, prother studies were well-there was no followed to the prother was | ent to the emergency room for ys. If having significant left upper ess. In was to follow-up with the next available appointment. If #2's hospital discharge //09/19 revealed: ent to the ER with complaints hours with dizziness. It was be being constant and he pain better or worse. It wup was negative. It wup recommendation. If #2's hospital discharge dated ed: If having chest pain around begressively got worse. If wup recommendation. If #2's hospital discharge dated ed: If having chest pain around begressively got worse. If hospital discharge dated ent to the emergency room for example of the emergency room for e |   |  |                               |                          |

Division of Health Service Regulation

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>PLETED         |
|--------------------------|--|---|---------------------|--|-------------------|--------------------------|
|                          |  | HAL060149   | B. WING             |  | 07/2              | 9/2019                   |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET ADI  | ORESS, CITY, S      | STATE, ZIP CODE  | -                 |                          |
| EAST TO                  | OWNE   |   |                     | N AMITY ROAD   |                   |                          |
| ··                       |  |   | TE, NC 282          |  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
| D 273                    | Continued From pa  | ge 52   | D 273               |  |                   |                          |
| D 273                    | -Her right leg was s below the knee, the with a reddish area right ankleShe was wearing a from above the knee below the right kneeThere was a quarte around the knee are Review of the Resid at 12:00pm revealed to reflect that Resid cardiologist.  Interview with Resid cardiologist. | wollen with a purplish bruising right foot was dark purple below the knee and above the a taped bandage that extended e to appropriately 2 inches a. er size area of dried blood ea on the bandage. Ident #2's record on 07/24/19 d there was no documentation ent #2 was referred to the dent #2 on 07/23/19 at the right week on her right leg hurts like crap." er to the dining room on her ehab after surgery, physical therapy at the facility. With Resident #2 on 07/29/19 d: f, but it's hard to move around ery.' se "I can't catch my breath | D 2/3               |  |                   |                          |
|                          | increased more sind<br>-She was sent to the<br>times this year for c<br>breath.<br>-She sometimes us   | ce she had the knee surgery. e emergency room multiple hest pain and shortness of ed an inhaler. n a cardiologist for being   |                     |  |                   |                          |

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 273 D 273 Continued From page 53 -The doctors did not seem to know why she was having chest pain. -She was told by the doctor that her shortness of breath would improve if she stopped smoking. Interview with the Lead Medication Aide on 07/24/19 at 10:45am revealed: -Resident #2 required almost total care since the knee surgery. -Theesident was sent to the emergency room early that morning (07/24/19) for chest pain and shortness of breath. -She reported that Resident #2 had shortness of breath and chest pain when she smoked and consumed alcohol. -The Resident Care Director (RCD), or the Resident Care Coordinator (RCC), usually processed the paperwork when a resident returned from the hospital or emergency room. -She was not aware that Resident #2 had orders to have consults with a cardiologist. Interview with the facility's Nurse Practitioner (NP) on 07/24/19 at 11:40am revealed: -He had not seen Resident #2 since she returned to the facility from having knee surgery. -Resident #2 needed to move to prevent blood clots and a stroke. -He was aware that Resident #2 had been sent to the emergency room multiple times for chest pain. -He was not aware that Resident #2 was sent out to the hospital 07/18/19, nor was he aware that Resident #2 was currently at the hospital. -He had examined Resident #2 in the past for the chest pain.

Division of Health Service Regulation

her.

-The resident's chest pain subsided when Milk of Magnesium ( a medicaion used to treat upset stomach and heart burn) was administered to

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | (X2) MULTIPL<br>A. BUILDING: | LE CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>PLETED         |
|--|---|------------------------------|--|-------------------|--------------------------|
|  | HAL060149   | B. WING                      | -  | 07/2              | 29/2019                  |
| NAME OF PROVIDER OR SUPPLIER   |   |                              | STATE, ZIP CODE  | ***               |                          |
| EAST TOWNE   |   | TH SHAROI<br>TE, NC 282      | N AMITY ROAD<br>205  |                   |                          |
| PREFIX (EACH DEFICIENCY MU   | MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) | JLD BE            | (X5)<br>COMPLETE<br>DATE |
| evaluated with the caral-He was not aware the see the cardiologist.  Telephone interview we the orthopedic doctor's 07/24/19 at 11:20AM resident #2 underwe arthroplasty on 07/16/-Their office was not a sent out to the hospital her surgery for chest puthe knee and leg pain.  A third interview with Feeded to have she did not know whe discharged.  The doctor was check sure she did not have linterview with the hospital-her surgery for chest puthe knee and leg pain.  A third interview with Feeded to have she did not know whe discharged.  The doctor was check sure she did not have linterview with the hospital-her she have linterview w | ad Resident #2 out to be radiologist. at Resident #2 had orders to with a representative from a soffice for Resident #2 on revealed: ent a right total knee for the second time since pain along with swelling in the second time since pain along with swelling in the second time since pain along with swelling in the second time since pain along with swelling in the second time since pain along with swelling in the second time since pain along with swelling in the second time since pain along with swelling in the second time since pain along with swelling in the second time since pain along with swelling in the second time since pain along the second time second | D 273                        |  |                   |                          |

(X2) MULTIPLE CONSTRUCTION

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING\_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 273 D 273 Continued From page 55 -She did not know what was going on with Resident #2 being sent out to the hospital. -She was not aware that Resident #2 had referrals to see a pulmonologist and the cardiologist. -The RCD and the RCC reviewed the paperwork from physician visits, hospital admissions, emergency room visits, and all the admission paperwork prior to giving the documents to the Medication Aides. -Sometimes the referrals and orders were put under put under her door, but the information was routed to RCD or the RCC to process. -Paperwork from doctor's appointments, hospital visits or emergency room visits "ended up all over the place." Interview with the RCC on 07/25/19 at 3:15pm and on 07/29/19 at 4:25pm revealed: -She was told that Resident #2 was sent out to the hospital on 07/18/19 and 07/24/19. -She was not aware Resident #2 needed appointments to see the caridiologisit. -She was not aware that Resident #2 was sent to ER 7 times since January for having chest pains. -She was not aware the last three ER visits occurred after her right knee placement that included Resident #2 having chest pain and experiencing pain and swelling of the right knee. Interview with the Licensed Health Professional Support (LHPS) Registered Nurse on 07/26/19 at 2:06pm revealed. -She had not completed an evaluation on Resident #2. -She expected staff to inform her of any changes in a resident's condition so she could assess the person to ensure proper care was being provided.

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | • ,                     | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|---|---|-------------------------|--|-------------------|--------------------------|
|   | HAL060149   | B. WING                 |  | 07/2              | 9/2019                   |
| NAME OF PROVIDER OR SUPPLIER  | STREET ADD  | DRESS, CITY, S          | TATE, ZIP CODE   |                   | . =                      |
| EAST TOWNE  |   | TH SHARON<br>TE, NC 282 | I AMITY ROAD<br>05   |                   |                          |
| PREFIX (EACH DEFICIENCY MUST  | ENT OF DEFICIENCIES<br>ET BE PRECEDED BY FULL<br>ENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE             | (X5)<br>COMPLETE<br>DATE |
| #2 was evaluated by the replacement on 07/16/19 Interview with Resident in 10:15am revealed: -She had knee surgery like whee on 07/16/19She had trouble bearing and stated, "my leg hurter to the empty of the emp | ent #2's record on led: Intation to reflect that ed to the pulmonologist. Intation to reflect Resident ed NP since her knee 9.  #2 on 07/23/19 at  last week on her right leg ts like crap."  #2 on 07/29/19 at  Intergency room multiple to pain and shortness of an inhaler. Interpulmonologist for being nest pain. Into to that her shortness of she stopped smoking.  Medication Aide on vealed: Into the emergency room ed (A/19) for chest pain and dent #2 had shortness of when she smoked and ector (RCC) usually risk when a resident tall or emergency room. Int Resident #2 had orders | D 273                   |  |                   |                          |

Division of Health Service Regulation

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 273 Continued From page 57 D 273 Interview with the facility's Nurse Practitioner (NP) on 07/24/19 at 11:40am revealed: -He had not seen Resident #2 since she returned to the facility from having knee surgery. -Resident #2 needed to move to prevent blood clots and a stroke. -He was not aware that Resident #2 was sent out to the hospital 07/18/19, nor was he aware that Resident #2 was currently at the hospital. -He had never referred Resident #2 out to be evaluated with the pulmonologist. -He was not aware that Resident #2 had orders to see the pulmonologist. Another interview with Resident #2 on 07/25/19 at 10:10am at the hospital revealed: -She continued to have some mild chest pain. -She did not know when she would be discharged. -The doctor was checking her heart and making sure she did not have a blood clot. Interview with the hospital Medical Doctor on 07/25/19 at 10:30am revealed: -Resident #2 had an elevated blood pressure. -Resident #2 was being weaned off of the oxygen. -Resident #2 needed to move around to prevent a blood clot or stroke. Interview with Lead Supervisor on 07/25/19 at 2:45pm revealed. -She did not know what was going on with

Division of Health Service Regulation

Resident #2 being sent out to the hospital. -She was not aware that Resident #2 had

-She did not recall seeing the referrals for Resident #2 to see a pulmonologist.

referrals to see a pulmonologist.

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION            | (X3) DATE<br>COMP  | SURVEY<br>LETED |                          |
|--|--|--|---------------------------|--|-----------------|--------------------------|
| HAL060149 B. WING 07   |  | 07/2   | 9/2019                    |  |                 |                          |
| NAME OF  | PROVIDER OR SUPPLIER   |  | DRESS, CITY, 5            | STATE, ZIP CODE  | 1 4172          |                          |
| EAST TO  | OWNE   |  | RTH SHARON<br>TTE, NC 282 | NAMITY ROAD<br>205   |                 |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE.          | (X5)<br>COMPLETE<br>DATE |
| D 273  | and on 07/29/19 at -She was told that if the hospital on 07/1 -She was not aware appointments to se Another confidentia 07/29/19 revealed: -Resident #2 was of for assistance over -She attempted to a resident required a -Resident #2 would rolling walker but ne -She had not seen the knee surgery.  Review of Resident summary dated 07/Resident #2 was s for a stabling like of -She reported havir 2. Review of Resident summary dated 07/Resident #2 was s for a stabling like of -She reported havir 2. Review of Resident endocrinology office resident missed a s scheduled on 02/12  Telephone interview on 07/24/19 at 8:40 -Resident #3 was a appointment for a c -Resident #3 had a | CC on 07/25/19 at 3:15pm 4:25pm revealed: Resident #2 was sent out to 8/19 and 07/24/19. Ethat Resident #2 needed Ethe pulmonologist.  I staff interview with on constantly ringing the call bell the past weekend. Essist Resident #2, but the two person assist. Try to move around with a Eseded staff assistance. Resident #2 walk since having  #2's hospital discharge 24/19 revealed: Esen in the emergency room the st pain. The shortness of breath.  Est #3's current FL2 dated diagnoses included chronic Est 2 diabetes, and peripheral  Est #3's letter from the referred Est dated 02/13/19 revealed the Est deduced appointment Est 19.  We with the endocrinology office am revealed: "no show" for his 02/12/19 | D 273                     |  |                 |                          |

PRINTED: 08/12/2019 FORM APPROVED

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING \_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 273 | Continued From page 59 D 273 provider cancelled the appointment. -Resident #3's next scheduled appointment was for 09/11/19. Interview with Resident #3 on 07/23/19 at 9:37am revealed: -He thought he had a referral to the endocrinologist; however, he had not been yet, -He was not sure why his endocrinology appointment had been rescheduled. -His blood sugars had been "kind of high" and he was not sure why they were high. Review of Resident #3's vital signs report revealed: -In May 2019, Resident #3's fingerstick blood sugars (FSBS) ranged from 122 mg/dL-337 mg/dL. -In June 2019, Resident #3's FSBS ranged 122mg/dL-386mg/dL. -In July 2019, Resident #3's FSBS ranged 121mg/dL-516mg/dL. Interview with the registered nurse (RN) for the primary care provider (PCP) for Resident #3 on 07/25/19 at 10:25am revealed: -Resident #3 was referred for a consultation with endocrinology on 01/29/19 for uncontrolled diabetes. -The PCP's office did not know Resident #3's first scheduled appointment with endocrinology was missed and the second appointment was cancelled by the endocrinology provider. -The PCP expected to be notified of missed and rescheduled appointments. -The PCP would have completed a consult with another endocrinologist. -The PCP would have expected the facility to communicate any missed or delayed appointments.

Division of Health Service Regulation

-It was important for Resident #3 to be seen by

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: \_ B. WING. 07/29/2019 HAL060149 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 273 D 273 Continued From page 60 the endocrinologist to prevent a decline in his health. Review of a medic report dated 06/17/19 for Resident #3 revealed upon arrival at the facility, Resident #3 had a blood glucose level of 60 mg/dL (reference range 65-100mg/dL). Review of a discharge summary from a local hospital for Resident #3 dated 06/20/19 revealed: -Resident #3 was admitted to the hospital on 06/17/19 with a primary diagnosis of encephalopathy (altered brain function). - "Patient's encephalopathy most likely from hypoglycemia (low blood sugar)". -Resident #3 was discharged back to the facility on 06/20/19. -Resident #3's A1C (test used to measure average blood glucose) was 5.6 mg/dL (reference range 4.0-6.0). Interview with the facility's contracted nurse practitioner (NP) on 07/24/19 at 1:05pm revealed: -He did not know Resident #3 had a referral for an endocrinology appointment. -He had been trying to get Resident #3's diabetes more controlled with medication. Review of Resident #3's laboratory results completed on 06/26/19 revealed the resident had an A1C of 7.3mg/dL, the reference range was 4.0-6.0. Interview with the lead medication aide/previous Resident Care Coordinator (RCC) on 07/24/19 at 10:48am revealed: -She did not realize Resident #3 had a referral for

Division of Health Service Regulation

an endocrinology in January 2019.

-She did not know Resident #3 missed an endocrinology appointment in February 2019.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | ъ. Г`  | E CONSTRUCTION   | (X3) DATE<br>COMP                 | PLETED                   |
|---|---|--|--|-----------------------------------|--------------------------|
|   | HAL060149   | B. WING  |  | 07/2                              | 29/2019                  |
| NAME OF PROVIDER OR SUPP  | LIER ST   | REET ADDRESS, CITY, S  | STATE, ZIP CODE  |                                   |                          |
| EAST TOWNE  |   | 15 NORTH SHAROI<br>HARLOTTE, NC 282                          |  |                                   |                          |
| PREFIX (EACH DEFIC  | Y STATEMENT OF DEFICIENCIES<br>IENCY MUST BE PRECEDED BY FUL<br>OR LSC IDENTIFYING INFORMATION  | ID<br>L PREFIX   | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| cancelled by the 2019She would have regarding a refunded in the control of the | endocrinology appointment vie endocrinology provider in several to another endocrinology provider in several to another endocrinology now Resident #3's A1C was reasonable.   | June<br>gist.<br>now   |  |                                   |                          |
| (RCC) on 07/2 -She became -The RCC was resident appoir -She did not keet an endocrinolor January 2019Resident #3's made sooner, scheduled 9 m -The endocrine contacted to s soonerThe referring contacted to g  Interview with (DRC) on 07/2 -She was hired -She was still the DRCShe knew she care of the res -The lead med were responsitive outlinedShe could no appointment s specialistShe was not seed the rese -She was not seed the rese  | now Resident #3 had a referringly consult that was made in appointment should have be "the appointment should not ronths out". Diogy office should have been see if the appointment could be physician could have been set a referral for another providing the Director of Resident Care 14/19 at 2:55pm revealed: 107/08/19 as the DRC, searning all of her responsibilities was responsible for the over | ral for een be nee der. e ities as erall CC ents. ed an oggy |  |                                   |                          |

6899

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|                          | OF CORDECTION  | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPL        | E CONSTRUCTION   | (X3) DATE |                          |
|--------------------------|--|---|---------------------|--|-----------|--------------------------|
| AND PLAN                 | ID PLAN OF CORRECTION   IDENTIFICATION NUMBER: A. BUILDING:                            |   | COMP                | LETED  |           |                          |
|                          |  |   | B 7841840           |  |           |                          |
|                          |  | HAL060149   | B. WING             |  | 07/2      | 9/2019                   |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                     | STATE, ZIP CODE  |           |                          |
| EAST TO                  | OWNE   |   |                     | N AMITY ROAD   |           |                          |
|                          | CUMMANDV CTA   |   | TE, NC 282          |  |           | 1                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE     | (X5)<br>COMPLETE<br>DATE |
| D 273                    | Continued From pa  | ge 62   | D 273               |  |           |                          |
|                          | -She completed a n<br>when she became t  | eview of Resident #3's record the DRC.  |                     |  |           |                          |
|                          | Interview with the A<br>9:22am revealed:   | dministrator on 07/24/19 at   |                     |  |           |                          |
|                          | -She expected the  | referral for Resident #3's  |                     |  |           |                          |
|                          |  | ultation to be discussed with<br>he provider cancelled to   |                     |  |           |                          |
|                          | determine next step  | os.   |                     |  |           |                          |
|                          | i - "We don't have the lim working on that   | e staff that goes back and call,  |                     |  |           |                          |
|                          |  | etween the cracks".   |                     |  |           |                          |
|                          | 01/16/19 revealed o  | ent #1's current FL-2 dated<br>liagnoses included<br>ype 2 diabetes mellitus.   |                     |  |           |                          |
|                          |  |   |                     |  |           | ,                        |
|                          | 05/06/19 revealed a  | #1's physician's orders dated<br>a medication order from her GI<br>ution reconstituted; use as<br>rep.  |                     |  |           |                          |
|                          | referral form reveal<br>an order from Resid<br>(NP) on 05/20/19 fo                     | #1's medical or emergency<br>ed the facility had requested<br>dent #1's Nurse Practitioner<br>or "GaviLyte-G (a bowel prep<br>lonoscopy done" and the NP<br>er on 05/22/19. |                     |  |           |                          |
|                          | sheet from the GI d -The date of the pro<br>crossed out with the<br>handwritten beside |   |                     |  |           |                          |

| PREFIX LEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX LEACH CORRECTIVE ACTION SHOULD BE COMPL  | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPI<br>A. BUILDING  | LE CONSTRUCTION | (X3) DATE<br>COMP   | SURVEY |                          |
|--|---|--|--|-----------------|---|--------|--------------------------|
| EAST TOWNE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY)  D 273  Continued From page 63  Resident #1 had a colonoscopy rescheduled for 07/15/19.  Review of Resident #1"refused colonoscopy on 05/20/19. Resident made office visit aware that she has eaten breakfast, however told staff that she did not eat breakfast. however fold staff that she did not eat breakfast. however fold staff that she did not eat breakfast."  Interview with Resident #1 on 07/23/19 at 10:10 am revealed:  -She missed a scheduled colonoscopy appointment when the prior week.  -She missed as cheduled colonoscopy appointment because the medication aide (MA) could not locate her "drink" with electrolytes" (bowel prep solution), she had to take the day before the colonoscopy appointment.  -The MA had asked another MA on duty that day and told Resident #1 that neither of them could locate her "drink" (bowel prep solution), -She did not know if her colonoscopy had been |   |  | HAL060149  | B. WING         |   | 07/2   | 29/2019                  |
| CHARLOTTE, NC 28205  (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 273  Continued From page 63  Resident #1 had a colonoscopy rescheduled for 07/15/19.  Review of Resident #1''s progress notes revealed: -There was documentation of a late entry dated 05/21/19 Resident made office visit aware that she has eaten breakfast, however told staff that she did not eat breakfast, however told staff that she did not eat breakfast, however told staff that she did not eat breakfast."  Interview with Resident #1 on 07/23/19 at 10:10am revealed: -She missed a scheduled colonoscopy appointment the prior weekShe missed the scheduled colonoscopy appointment because the medication aide (MA) could not locate her "drink with electrolytes" (bowel prep solution) she had to take the day before the colonoscopy appointmentThe MA had asked another MA on duty that day and told Resident #1 that neither of them could locate her "drink" (bowel prep solution)She did not know if her colonoscopy had been   | NAME OF   | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY,    | STATE, ZIP CODE   |        |                          |
| PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 273  Continued From page 63  Resident #1 had a colonoscopy rescheduled for 07/15/19.  Review of Resident #1's progress notes revealed: -There was documentation of a late entry dated 05/21/19 Resident #1 "refused colonoscopy on 05/20/19. Resident #1 "refused colonoscopy on 05/20/19. Resident make office visit aware that she did not eat breakfast."  -There was documentation dated 07/15/19 Resident #1's "appointment with [GI practice name] has been rescheduled due to resident being non-compliant and eating breakfast."  Interview with Resident #1 on 07/23/19 at 10:10am revealed: -She missed a scheduled colonoscopy appointment the prior weekShe missed the scheduled colonoscopy appointment because the medication aide (MA) could not locate her "drink with electrolytes" (bowel prep solution) she had to take the day before the colonoscopy appointmentThe MA had asked another MA on duty that day and told Resident #1 that neither of them could locate her "drink" (bowel prep solution)She did not know if her colonoscopy had been   | EAST TO   | OWNE   |  |                 |   |        |                          |
| Resident #1 had a colonoscopy rescheduled for 07/15/19.  Review of Resident #1's progress notes revealed: -There was documentation of a late entry dated 05/21/19 Resident #1 "refused colonoscopy on 05/20/19. Resident made office visit aware that she has eaten breakfast, however told staff that she did not eat breakfast." -There was documentation dated 07/15/19 Resident #1's "appointment with [GI practice name] has been rescheduled due to resident being non-compliant and eating breakfast."  Interview with Resident #1 on 07/23/19 at 10:10am revealed: -She missed a scheduled colonoscopy appointment the prior weekShe missed the scheduled colonoscopy appointment because the medication aide (MA) could not locate her "drink with electrolytes" (bowel prep solution) she had to take the day before the colonoscopy appointmentThe MA had asked another MA on duty that day and told Resident #1 that neither of them could locate her "drink" (bowel prep solution)She did not know if her colonoscopy had been  | PRÉFIX  | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL   | PREFIX          | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO | LD BE  | (X5)<br>COMPLETE<br>DATE |
| Review of Resident #1's progress notes revealed: -There was documentation of a late entry dated 05/21/19 Resident #1 "refused colonoscopy on 05/20/19. Resident made office visit aware that she has eaten breakfast, however told staff that she did not eat breakfast."  -There was documentation dated 07/15/19 Resident #1's "appointment with [GI practice name] has been rescheduled due to resident being non-compliant and eating breakfast."  Interview with Resident #1 on 07/23/19 at 10:10am revealed: -She missed a scheduled colonoscopy appointment the prior weekShe missed the scheduled colonoscopy appointment because the medication aide (MA) could not locate her "drink with electrolytes" (bowel prep solution) she had to take the day before the colonoscopy appointmentThe MA had asked another MA on duty that day and told Resident #1 that neither of them could locate her "drink" (bowel prep solution)She did not know if her colonoscopy had been  | D 273   | Continued From pa  | ge 63  | D 273           |   |        |                          |
| -There was documentation of a late entry dated 05/21/19 Resident #1 "refused colonoscopy on 05/20/19. Resident made office visit aware that she has eaten breakfast, however told staff that she did not eat breakfast."  -There was documentation dated 07/15/19 Resident #1's "appointment with [GI practice name] has been rescheduled due to resident being non-compliant and eating breakfast."  Interview with Resident #1 on 07/23/19 at 10:10am revealed: -She missed a scheduled colonoscopy appointment the prior weekShe missed the scheduled colonoscopy appointment because the medication aide (MA) could not locate her "drink with electrolytes" (bowel prep solution) she had to take the day before the colonoscopy appointmentThe MA had asked another MA on duty that day and told Resident #1 that neither of them could locate her "drink" (bowel prep solution)She did not know if her colonoscopy had been   |   |  | colonoscopy rescheduled for  |                 |   |        |                          |
| -She had never refused to go to a colonoscopy appointmentShe would sometimes forget and eat breakfast on the morning of her colonoscopy appointments.  Telephone interview with Resident #1's GI physician on 07/24/19 at 9:41am revealed: -Resident #1 had been referred to him for a colonoscopy by her Primary Care Provider (PCP)He saw Resident #1 for a consultation on  |   | -There was docume 05/21/19 Resident # 05/20/19. Resident # she did not eat breathere was docume Resident #1's "appointment has been resident #1's "appointment with Resident # 10:10am revealed: -She missed a sche appointment the pricashe missed the scheme appointment because could not locate her (bowel prep solution before the colonosco-The MA had asked and told Resident # locate her "drink" (b-She did not know if rescheduledShe had never refurappointmentShe would sometiment on the morning of here interview physician on 07/24/-Resident #1 had be colonoscopy by here | entation of a late entry dated #1 "refused colonoscopy on made office visit aware that kfast, however told staff that elkfast." entation dated 07/15/19 pointment with [GI practice scheduled due to resident and eating breakfast."  Hent #1 on 07/23/19 at eluled colonoscopy or week. Heduled colonoscopy or we |                 |   |        |                          |

| Division of Health Service Regulation   |                     |   |                   |                          |
|---|---------------------|---|-------------------|--------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA   |                     | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED          |
| HAL060149   | B. WING             |   | 07/2              | 9/2019                   |
| NAME OF PROVIDER OR SUPPLIER STREET ADDI  | RESS, CITY, S       | STATE, ZIP CODE   |                   |                          |
| FACT TOWNS 4815 NORT  | TH SHARON           | NAMITY ROAD   |                   |                          |
| EAST TOWNE CHARLOTT   | TE, NC 282          | 05  |                   |                          |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| D 273 Continued From page 64  | D 273               |   |                   |                          |
| Resident #1 had a history of colon polyps removed approximately 9 years prior.  -He scheduled Resident #1 for a colonoscopy on 05/06/19.  -Resident #1 was a "no show" to the 05/06/19 colonoscopy appointment and was rescheduled for a colonoscopy on 05/20/19.  -Resident #1 was a "no show" to the 05/20/19 colonoscopy appointment and was rescheduled for a colonoscopy on 07/15/19.  -Resident #1 was a "no show" to the 07/15/19 colonoscopy appointment.  -Patients undergoing a colonoscopy had to follow certain instructions or else he could not perform the colonoscopy.  -These instructions included adhering to a clear liquid diet the day prior to the scheduled colonoscopy, holding their diabetic medications the day prior and until after the colonoscopy, have nothing to eat after midnight the night prior to the colonoscopy and drink the full container of bowel prep solution starting at 5:00pm the evening prior to the colonoscopy.  -These written instructions and a prescription for the bowel prep solution were provided to the transportation driver and faxed to the facility on the day of Resident #1's initial consultation and faxed to the facility every day that she was a "no show" to her colonoscopy appointments.  -A representative from his office also contacted the facility 2 days prior to each scheduled colonoscopy to verbally remind the staff of these instructions.  -Facility staff reported to his office they did not bring Resident #1 to her three scheduled colonoscopy appointments because they did not administer her bowel prep solution the day prior and Resident #1 was also allowed to eat breakfast the morning of the scheduled |                     |   |                   |                          |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPL<br>A. BUILDING:   | LE CONSTRUCTION     | (X3) DATE<br>COMP  | SURVEY<br>PLETED |                          |
|--|--|--|---------------------|--|------------------|--------------------------|
|  |  | HAL06014 <del>9</del>  | B. WING             |  | 07/2             | 29/2019                  |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  | <u></u>          |                          |
| EAST TO  | OWNE   |  | TH SHAROI           | N AMITY ROAD<br>205  | ·                |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE            | (X5)<br>COMPLETE<br>DATE |
| D 273  | -It was very importaresidents were admissidents were admissidents were admissidents. "The rithings themselves." -With Resident #1's in the stool, and blocolon polyps at president for another at the facility could aresponsibility for fol preparation instruct be required to have appointment.  Interview with Resident #1 and missed 3 so appointmentsIf he had been notification with Resident #1 and missed the appointment with Resident #1 the missed the appointmentsIf he had been notification with Resident #1 could own preparation for with her psychiatric and the morning of the country the MAs should be Resident #1 adhere eat breakfast and discovered. | ant for facility staff to assure sinistered the bowel prepared the other colonoscopy esidents cannot do these shistory of colon polyps, blood ating she could have more sent or colon cancer. "We just e has the colonoscopy]." he would not reschedule the colonoscopy until someone assure him, they would take lowing through with the ions, and the resident would another consultation  dent #1's Nurse Practitioner 12:07pm revealed: esident #1 to the GI for a puttine screening. The mber being notified Resident heduled colonoscopy  fied, he would have discussed to find out why she had ments and provided ecessary, but he could not not it with her.  not be expected to assure her the colonoscopy especially | D 273               | ELINIEROTY   |                  |                          |

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING \_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 273 | Continued From page 66 D 273 Medication Administration record (eMAR) revealed: -There was no entry for the bowel prep solution to be administered on 05/05/19 prior to the 05/06/19 scheduled colonoscopy. -There was no entry for the bowel prep solution to be administered on 05/19/19 prior to the 05/20/19 scheduled colonoscopy. -There was an entry for the bowel prep solution (GaviLyte) to be administered at 8:00am on 05/23/19 with documentation it had not been administered. Review of Resident #1's July 2019 eMAR revealed there was an entry for the bowel prep solution GaviLyte to be administered at 5:00pm on 07/14/19 with documentation it had not been administered. Interview with a first shift MA on 07/24/19 at 11:45am revealed: -She had never administered bowel prep solution to Resident #1. -She had only seen bowel prep solution populated on the eMAR on one occasion for Resident #1 and that was on 05/23/19. -She asked the Lead MA/previous Resident Care Cooordinator (RCC) if she should administer the bowel prep on 05/23/19 and she was told she could not because Resident #1 did not have a colonoscopy scheduled for the following day. Telephone interview with a second shift MA on 07/25/19 at 11:35am revealed: -She had never administered bowel prep solution to Resident #1. -She had only seen bowel prep solution populated on the eMAR on one occasion for Resident #1 and that was on 07/14/19.

Division of Health Service Regulation

-She did not administer the bowel prep solution to

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 273 Continued From page 67 D 273 Resident #1 on 07/14/19 because she could not locate it in the facility. -She asked another MA if she knew where it was, and she could not locate it either. -She did not attempt to contact the pharmacy or a supervisor to help her locate the bowel prep solution. Telephone interview with a representative from the facility's contracted pharmacy on 07/24/19 at 9:06am revealed: -They had received only one order from the facility for Resident #1's bowel prep solution (GaviLyte). -The GaviLyte order was received on 05/22/19 and the pharmacy dispensed a one-time supply on the same day. A second telephone interview with a representative from the facility's contracted pharmacy on 07/25/19 at 10:37am revealed: -The facility faxed physician's orders to the pharmacy. -The pharmacy entered the orders into the eMAR system. -If the order provided a start date, the pharmacy would enter the medication onto the eMAR for that date. -If the order did not provide a start date, the pharmacy would enter the medication onto the eMAR for the following day. -If the physician's order was new, the facility had to go into the eMAR system and approve it before it would populate onto the eMAR for administration. -The pharmacy entered Resident #1's GaviLyte order received on 05/22/19 for the following day (05/23/19) because it did not have a start date.

Division of Health Service Regulation

-The facility had the ability to adjust dates and times of scheduled administration, if necessary,

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 273 Continued From page 68 D 273 to coordinate the bowel prep solution with the scheduled colonoscopy. Interview with the Lead MA/RCC on 07/24/19 at 12:49pm revealed: -She had worked at the facility since 04/16/19. -Processes were very different in the Assisted Living Facility (ALF) and she had received no training on those processes when she began -She did not know Resident #1 was scheduled for a colonoscopy on 05/06/19. -Whichever facility staff received the order for the bowel prep solution given at Resident #1's GI consult on 04/12/19 should have faxed the order to the pharmacy and given the colonoscopy date to the RCC who was employed at that time. -She knew Resident #1 had a colonoscopy scheduled for 05/20/19 and thought she missed it because she had eaten breakfast that morning. -She did not know Resident #1 was not administered the bowel prep solution on 05/19/19. -She did not know why Resident #1's order for the bowel prep solution dated 05/06/19 had not been sent to the pharmacy so that it could have been administered the day prior to her 05/20/19 colonoscopy appointment. -It would have been her responsibility to fax the bowel prep solution order to the pharmacy because she was the RCC at that time. -She did not know why an order for the bowel prep solution had been requested from Resident #1's NP on 05/20/19 when they already had an order from the GI dated 05/06/19. -She knew Resident #1 had a colonoscopy scheduled on 07/15/19. -Resident #1 missed her colonoscopy on 07/15/19 because the bowel prep solution was

Division of Health Service Regulation

not administered on 07/14/19.

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION      | (X3) DATE<br>COMP  | SURVEY<br>LETED |                          |
|--|---|--|---------------------|--|-----------------|--------------------------|
|  |   | HAL060149  | B. WING             |  | 07/2            | 9/2019                   |
| NAME OF  | PROVIDER OR SUPPLIER  |  | DRESS, CITY, 8      | STATE, ZIP CODE  | , ,,,,          |                          |
| EAST TO  | OWNE  | •  |                     | N AMITY ROAD   |                 |                          |
|  |   | CHARLOT  | TE, NC 282          |  |                 |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE           | (X5)<br>COMPLETE<br>DATE |
| D 273  | Continued From pa   | ge 69  | D 273               |  |                 |                          |
| D 273  | -The bowel prep so 07/14/19 because the solution medication roomShe expected the four supervisor if they could but the MA did not could be a supervisor if they could be a supervisor i | lution was not administered on the MA on duty that day could on even though it was in the MAs to call her or another ould not locate a medication, do so.  CC on 07/25/19 at 2:33pm  RCC since 07/08/19.  RCC since 07/08/19.  RCC since 07/08/19.  RCC since Provider (PCP) to not schedule the appointments. Sonsible for faxing new orders approving those orders in after they were entered by the foliation in the eMAR system if it is such as bowel preparation in the eMAR system if it is such as bowel preparation in the employed on the form the colonoscopy. The colonoscopy is such as and the Dietary Manager are sident not being a resident no | D 273               |  |                 |                          |
|  | #1's 05/06/19 and 0 colonoscopy appoir  | 5/20/19 scheduled  |                     |  |                 |                          |

Division of Health Service Regulation

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPL<br>A. BUILDING: | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY                   |
|--------------------------|--|---|------------------------------|---|-------------------|--------------------------|
|                          | ,  |   |                              |   |                   |                          |
|                          |  | HAL060149   | B. WING                      |   | 07/2              | 9/2019                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, S               | STATE, ZIP CODE   |                   |                          |
| EAST TO                  | OWNE   |   | TH SHAROI<br>TE, NC 282      | N AMITY ROAD  |                   |                          |
| (XA) ID                  | SLIMMADY STA   | TEMENT OF DEFICIENCIES  | •                            | PROVIDER'S PLAN OF CORRECTI   | ON                |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| D 273                    | Continued From pa  | ge 70   | D 273                        |   |                   |                          |
|                          | the bowel prep solushe ate breakfast on Resident #1 was not prep solution on 07, not locate it even the room.  The MA should have pharmacy to help he solution, but she did not locate it even the room.  The MA should have pharmacy to help he solution, but she did not locate it even the solution, but she did not locate in the locate in th | ot administered the bowel /14/19 because the MA could rough it was in the medication we contacted either her or the er locate the bowel prep d not.  M on 07/25/19 at 3:09pm  this facility since 06/12/19. The of one resident who had he had worked at the facility. It was a morning stand up other dietary staff's sure the resident was not. |                              |   |                   |                          |
|                          | 9:04am revealed: -She had worked at -The RCC was resp appointments, send and setting up trans -The pharmacy ente solutions into a resi -Once the bowel pre the facility, it was the verify and approve to eMAR by the pharm -The RCC was resp  | dministrator on 07/25/19 at this facility for 3 weeks. consible for scheduling ling orders to the pharmacy sportation for colonoscopies. ered orders for bowel prep dent's computer profile. ep solution was dispensed to e RCC's responsibility to the order entered onto the  |                              |   |                   |                          |

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 273 Continued From page 71 D 273 administered based on the date of the colonoscopy appointment. -The RCC was responsible for assuring all instructions for colonoscopy preparation were followed by the MAs. -The Administrator or the RCC would communicate instructions regarding clear liquid diet orders and NPO orders to the DM. -The DM was responsible for assuring the resident was served only clear liquids the day prior to the colonoscopy and was not served breakfast the day of the scheduled colonoscopy. -She provided oversight to both the RCC and DM. -The bowel prep solution should not have been on the eMAR to be administered to Resident #1 on 05/23/19 because she did not have a colonoscopy scheduled for 05/24/19. -The bowel prep solution should have been on the eMAR and available for administration on 05/05/19 and 05/19/19 for Resident #1. -She was told Resident #1 missed all three colonoscopy appointments because she refused to go and then ate breakfast. -It would not have mattered if Resident #1 ate breakfast on the day of the colonoscopy appointment because she would not have been able to have the colonoscopy performed anyway due to not being administered the bowel prep solution the day prior. 4. Review of Resident #8's current FL-2 dated 01/16/19 revealed diagnoses included Parkinson's diseaseand major depression.

Division of Health Service Regulation

(gastroenterologist).

Review of Resident #8's subsequent physician's orders dated 03/03/19 revealed an order for a

Review of Resident #8's physician's orders dated

colorectal cancer screening with GI

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ' '                     | E CONSTRUCTION   | COMPLETED |                          |
|--|--|--|-------------------------|--|-----------|--------------------------|
|  |  |  | P. M.N.O.               |  |           |                          |
|  |  | HAL060149  | B. WING                 |  | 07/2      | 9/2019                   |
| NAME OF I  | PROVIDER OR SUPPLIER   |  |                         | STATE, ZIP CODE  |           |                          |
| EAST TO  | OWNE   |  | TH SHARON<br>TE, NC 282 | I AMITY ROAD<br>05   |           |                          |
| (X4) ID<br>PREFIX<br>TAG   |  |  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE      | (X5)<br>COMPLETE<br>DATE |
| D 273  | Continued From pa  | ge 72  | D 273                   |  |           |                          |
|  | for Golytely oral sol<br>directed for bowel p  | •  |                         |  |           |                          |
|  | referral form reveal<br>an order from Resid<br>(NP) on 05/20/19 fo   | #8's medical or emergency<br>ed the facility had requested<br>dent #8's Nurse Practitioner<br>or "GaviLyte-G (a bowel prep<br>elonoscopy done" and the NP<br>er on 05/22/19. |                         |  |           |                          |
|  | Review of Resident #8's colonoscopy instructions sheet from the GI dated May 2019 revealed: -The date of the procedure was crossed out with the words "No Show" written beside it. The date was May 2019 with the day being illegible because it was crossed throughThere was a handwritten note documenting Resident #8 had a colonoscopy rescheduled for 05/13/19 with the words "No Show" written beside itThere was a handwritten note documenting Resident #8 had a colonoscopy rescheduled for 07/15/19. |  |                         |  |           |                          |
|  | there was documer<br>Resident #8's "appo<br>name] has been ca  | t #8's progress notes revealed<br>htation dated 07/15/19<br>pintment with [GI practice<br>incelled due to resident being<br>eating breakfast this morning."                  |                         |  |           |                          |
|  | Attempted interview at 3:43pm was uns  | v with Resident #8 on 07/25/19<br>uccessful.   |                         |  |           |                          |
|  | Medical Assistant of<br>revealed:<br>-Resident #8 had b<br>colonoscopy by her  | dent #8's GI physician's<br>on 07/25/19 at 11:22am<br>een referred to GI for a<br>Primary Care Provider (PCP).<br>een seen by the GI on                                      | ,                       |  |           |                          |

Division of Health Service Regulation

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 273 Continued From page 73 D 273 04/12/19 for a consultation, -It was difficult for them to understand Resident #8 due to a language barrier, but as far as they could understand, she was not experiencing any symptoms but had never had a colonoscopy performed. -It was important for all residents to have a colonoscopy performed at least every 10 years beginning at age 50 and Resident #8 was over the age of 70. -Resident #8 was scheduled for a colonoscopy on 05/03/19. -Resident #8 was a "no show" to the 05/03/19 colonoscopy appointment and was rescheduled for a colonoscopy on 05/13/19. -Resident #8 was a "no show" to the 05/13/19 colonoscopy appointment and was rescheduled for a colonoscopy on 07/15/19. -Resident #8 was a "no show" to the 07/15/19 colonoscopy appointment, -Patients undergoing a colonoscopy had to follow certain instructions or else a colonoscopy could not be performed. -These instructions included adhering to a clear liquid diet the day prior to the scheduled colonoscopy, have nothing to eat after midnight the night prior to the colonoscopy and drink the full container of bowel prep solution starting at 5:00pm the evening prior to the colonoscopy. -These written instructions and a prescription for the bowel prep solution were provided to the transportation driver and faxed to the facility on the day of Resident #8's initial consultation and faxed to the facility every day that she was a "no show" to her colonoscopy appointments. -Representatives from their office also contacted

Division of Health Service Regulation

instructions.

the facility 2 days prior to each scheduled colonoscopy to verbally remind the staff of these

-Facility staff reported to the GI office they did not

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  |        | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|--|--------|-------------------------------|--|
|   | HAL060149  | B. WING                                  |  | 07/2   | 9/2019                        |  |
| NAME OF PROVIDER OR SUPF  | JIER STREET AU   | DRESS, CITY, S                           | TATE, ZIP CODE   |        |                               |  |
| EAST TOWNE  |  | RTH SHARON<br>TTE, NC 282                | I AMITY ROAD   |        |                               |  |
| PRÉFIX (EACH DEFIC  | STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | ILD BE | (X5)<br>COMPLETE<br>DATE      |  |
| colonoscopy a administer her and Resident # breakfast the r colonoscopiesAfter 3 "no shis schedule resid they had anoth -The GI physic Resident #8 for facility could as responsibility for instructions.  Review of Res Medication Administered was no be administered scheduled color. There was no be administered scheduled color. There was an (GaviLyte) to be 1:00 am with deadministered.  Review of Res revealed there solution GaviLy at 5:00 pm with administered.  Interview with administered.  Interview with administered.  Interview with administered. | #8 to her three scheduled pointments because they did not powel prep solution the day prior 8 was also allowed to eat corning of the scheduled pws," their office would not ents for another colonoscopy until er consultation with the GI. an was not willing to reschedule another consultation until the sure him, they would take in following the preparation dent #8's May 2019 Electronic inistration record (eMAR) entry for the bowel prep solution to d on 05/02/19 prior to the 05/03/19 noscopy. |  |  |        |                               |  |

Division of Health Service Regulation

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 273 Continued From page 75 D 273 Resident #8's GaviLyte populating on the eMAR for administration. -She did not administer the GaviLyte but documented she had administered it "probably because she was so busy." Telephone interview with a representative from the facility's contracted pharmacy on 07/25/19 at 10:37am revealed: -The facility faxed physician's orders to the pharmacy. -The pharmacy entered the orders into the eMAR system. -If the order provided a start date, the pharmacy would enter the medication onto the eMAR for that date. -If the order did not provide a start date, the pharmacy would enter the medication onto the eMAR for the following day. -If the physician's order was new, the facility had to go into the eMAR system and approve it before it would populate onto the eMAR for administration. -The pharmacy had received only one order for Resident #8's bowel prep solution. -The pharmacy received an order for Resident #8's GaviLyte on 05/22/19 and dispensed a one-time supply to the facility on the same day. -The pharmacy entered Resident #8's GaviLyte order onto the eMAR for the following day (05/23/19) because it did not have a start date. -The facility had the ability to adjust dates and times of scheduled administration, if necessary, to coordinate the bowel prep solution with the

Division of Health Service Regulation

revealed:

scheduled appointments.

Interview with the RCC on 07/25/19 at 2:33pm

-She had been the RCC since 07/08/19.
-It was the RCC's responsibility to fax referrals

|               | NT OF DEFICIENCIES<br>OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:     | (X2) MULTIPL<br>A. BUILDING: | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY           |
|---------------|-------------------------------------|---|------------------------------|---|-------------------|------------------|
|               |                                     |   |                              |   |                   |                  |
|               |                                     | HAL060149   | B. WING                      |   | 07/2              | 29/2019          |
| NAME OF       | PROVIDER OR SUPPLIER                | STREET ADI  | ORESS, CITY, S               | STATE, ZIP CODE   |                   |                  |
| EAST TO       | OWNE                                |   | TH SHAROI<br>TE, NC 282      | N AMITY ROAD<br>205   |                   |                  |
| (X4) ID       | SUMMARY STA                         | TEMENT OF DEFICIENCIES                                    | ID                           | PROVIDER'S PLAN OF CORRECTI   | ON                | (X5)             |
| PRÉFIX<br>TAG |                                     | 'MUST BE PRECEDED BY FULI.<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG                | (EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE<br>PRIATE   | COMPLETE<br>DATE |
| D 273         | Continued From pa                   | ge 76   | D 273                        |   |                   |                  |
|               | made by the Primar                  | y Care Provider (PCP) to                                  |                              |   |                   |                  |
|               | outside providers ar                | nd schedule the appointments.                             |                              |   |                   |                  |
|               |                                     | onsible for faxing new orders                             |                              |   |                   |                  |
|               |                                     | d approving those orders in                               |                              |   |                   |                  |
|               | tne elviAR system a pharmacy.       | fter they were entered by the                             |                              |   |                   |                  |
|               |                                     | ility of adjusting dates and                              |                              |   |                   |                  |
|               |                                     | ion in the eMAR system if                                 |                              |   |                   |                  |
|               |                                     | ons such as bowel prep                                    |                              |   |                   |                  |
|               |                                     | idministered based on the                                 |                              |   |                   |                  |
|               | appointment date for                |   |                              |   |                   |                  |
|               | -The RCC was resp                   | onsible for printing                                      |                              |   |                   |                  |
|               |                                     | rg a resident not being<br>rfast and providing those      |                              |   |                   |                  |
|               |                                     | MAs and the Dietary Manager                               |                              |   |                   | ļ                |
|               | (DM).                               | a to arra the Bretary manager                             |                              |   |                   |                  |
|               |                                     | ructions regarding clear liquid                           |                              |   |                   |                  |
|               | diets to the MAs and                |   |                              |   |                   |                  |
|               |                                     | nsible for assuring residents                             |                              |   |                   |                  |
|               |                                     | were served appropriate                                   |                              |   |                   |                  |
|               | liquids.<br>-The DM was resno       | nsible for assuring residents                             |                              |   |                   |                  |
|               |                                     | hing by mouth) would not be                               |                              |   |                   |                  |
|               | served breakfast.                   | in ig a <b>y</b> maan, waana not a c                      |                              |   |                   |                  |
|               | -She did not work at                | t the facility during Resident                            |                              |   |                   |                  |
|               | #8's 05/03/19 and 0                 |   |                              |   |                   |                  |
|               | colonoscopy appoin                  |   |                              |   | 1                 |                  |
|               |                                     | d her 07/15/19 colonoscopy                                |                              |   |                   |                  |
|               |                                     | se she was not administered tion on 07/14/19 and because  |                              |   |                   |                  |
|               | she ate breakfast o                 |   |                              |   |                   |                  |
|               | ,                                   | why the MA did not administer                             |                              |   |                   |                  |
|               |                                     | tion to Resident #8 on                                    |                              |   |                   |                  |
|               | 07/14/19.                           |   |                              |   |                   |                  |
|               | Interview with the D                | M on 07/25/19 at 3:09pm                                   |                              |   |                   |                  |
|               | revealed:                           |   |                              |   |                   |                  |
|               |                                     | his facility since 06/12/19.                              |                              |   |                   |                  |
|               |                                     | of one resident who had                                   |                              |   |                   |                  |
|               | been on a clear liqu                | id diet and NPO for a                                     |                              |   |                   |                  |

Division of Health Service Regulation

PRINTED: 08/12/2019

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 273 Continued From page 77 D 273 colonoscopy since he had worked at the facility. -The RCC had verbally communicated the information to him during a morning stand up meeting. -It was his and the other dietary staff's responsibility to assure the resident was not served breakfast. -He was never told Resident #8 was to be on a clear liquid diet or NPO. Interview with the Administrator on 07/25/19 at 9:04am revealed: -She had worked at this facility for 3 weeks. -The RCC was responsible for scheduling appointments, sending orders to the pharmacy and setting up transportation for colonoscopies. -The pharmacy entered orders for bowel prep solutions into a resident's computer profile. -Once the bowel prep solution was dispensed to the facility, it was the RCC's responsibility to verify and approve the order entered onto the eMAR by the pharmacy. -The RCC was responsible for entering the date on the eMAR the bowel prep solution should be administered based on the date of the colonoscopy appointment. -The RCC was responsible for assuring all instruction for colonoscopy preparation were followed by the MAs. -The Administrator or the RCC would communicate instructions regarding clear liquid diet orders and NPO orders to the DM. -The DM was responsible for assuring the resident was served only clear liquids the day prior to the colonoscopy and was not served breakfast the day of the scheduled colonoscopy. -She provided oversight to both the RCC and DM.

Division of Health Service Regulation

The facility failed to assure follow-up with

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1 ' '                    | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|--|--------------------------|--|-------------------|--------------------------|
| :                        |  | HAL060149  | B. WING                  |  | 07/2              | 9/2019                   |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                          | STATE, ZIP CODE  |                   |                          |
| EAST TO                  | PWNE   |  | TH SHAROI<br>TTE, NC 282 | NAMITY ROAD<br>205   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | .D BE             | (X5)<br>COMPLETE<br>DATE |
| D 273                    | physician's orders fordered a cardiolog which led to a re-adfor chest pains; Resendocrinology consuncontrolled diabete in an elevated A1C, encephalopathy, and gldL, and the princontacted; Residen of polyps, blood in the bloating who misse appointments; and had a colon cancer consecutive colono failure to assure he on physician's orde harm and neglect a Violation. This Type previous survey.  The facility provided accordance with G. | or Resident #2 who was y and pulmonology consult Imission to the local hospital sident #3 who missed an ult for treatment of es as ordered, which resulted hospitalization for Id a blood glucose of 60 mary care provider was never that who had a medical history he stool, and stomach did a consecutive colonoscopy Resident #8 who had never screening and missed a scopy appointments. This althcare referral and follow-up resulted in serious physical and constitutes a Type A1 and a plan of protection in S. 131 D-34 on 07/26/19.  TE FOR THE UNABATED DN SHALL NOT EXCEED | D 273                    |  |                   |                          |
| D 276                    | 10A NCAC 13F .09   | 02(c)(3-4) Health Care   | D 276                    | 10A NCAC 13F .0902(c) (3-4)  |                   |                          |
|                          | following in the residual (3) written procedured a physician or other and (4) implementation   | assure documentation of the  |                          | Facility management will ensure documentation of written procedures, treatments or of from a physician or licensed health professional; and implementation of procedures, treatmentsor orders in the resident's record | n<br>of           | 8/26/19                  |

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|  | IT OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ' '  | E CONSTRUCTION   | (X3) DATE     | SURVEY<br>LETED          |
|--|---|---|--|--|---------------|--------------------------|
| ANDILAN  | OF CONNECTION   | IDENTIFICATION NONBER.  | A. BUILDING:   |  | COMP          | LETED                    |
|  | <u></u>   | HAL060149   | B. WING  |  | 07/2          | 9/2019                   |
| NAME OF I  | PROVIDER OR SUPPLIER  | STREET ADI  | ORESS, CITY, S   | STATE, ZIP CODE  |               |                          |
| EAST TO  | WNF   | 4815 NOR  | TH SHARO   | N AMITY ROAD   |               |                          |
| LAUTIC   | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  | CHARLOT   | TE, NC 282   | 205  |               |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)  | D BE          | (X5)<br>COMPLETE<br>DATE |
| D 276  | Continued From pa   | ge 79   | D 276  | Continued from page 79   |               | · · · · ·                |
|  |   |   |  | Facility has conducted a complete audit of all medication orders, physician orders and EMARs.  |               | 8/26/19                  |
| This Rule is not met as evidenced by: TYPE A1 VIOLATION  Based on observations, interviews, and record |   |   | Senior VP of Clinical Services initiated a team of experianced Resident Care Directors to comple audit of all EMARs and Physicains which included review of paramete | order :  | 8/21/19       |                          |
|  |   |   | Facility Pharmacy has conducted a<br>On-site Medication cart audit of all<br>medications.  | n  | 8/22/19       |                          |
|  | orders were implementated to scheduled colonosc   | failed to assure physicians' pented for 3 of 7 sampled preparation instructions for copies (#1 and #8), medication er stick blood sugar checks, checks (#3).  |  | Facility RCC and/or Lead SIC's will continue to complete weekly medication cart audits. Documental of cart audit will be noted on a track Tracking form will be signed by per-                               | king forms    | 8/26/19                  |
|  | 07/03/19 revealed of<br>kidney disease, type<br>neuropathy, history   | ent #3's current FL-2 dated<br>liagnoses included chronic<br>e 2 diabetes, peripheral<br>of cerebral vascular disease<br>ness, and hypertension.  |  | completing audit and ED.  Facility RCC and/or DRC will review approve medication orders, treatme any orders with parameters prior to implemention and/or administration  Facility ED, RCC, DRC and/or design | ents and      | 8/26/19                  |
|  | a. Review of Resided dated 12/28/18 reverse 100 units/mL inject: before meals and ar-The sliding scale wunits, 201-250; 4 units, 351-400; 10 the emergency room | ent #3's physician's orders<br>ealed:<br>r to administer Novolog insulin<br>2 to 10 units (sliding scale)<br>t bedtime for diabetes.<br>ras as follows: 150-200; 2<br>iits, 251-300; 6 units, 301-350;<br>units, if greater than 401 go |  | will ramdonly audit EMARS against Physicians order on going.  Divisional Director of Clincial Servic has made weekly visits to facility to review clinical process with Medical Orders                       | es<br>assist/ | 8/26/19                  |

Division of Health Service Regulation

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | • •                 | E CONSTRUCTION  | (X3) DATE :<br>COMPI                 |  |
|--------------------------|---|---|---------------------|---|--------------------------------------|--|
|                          |   | HAL060149   | B. WING             |   | 07/2                                 | 9/2019   |
| NAME OF I                | PROVIDER OR SUPPLIER  | 4815 NOR  |                     | STATE, ZIP CODE<br>N AMITY ROAD   |                                      | ,,   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)   | D BE                                 | (X5)<br>COMPLETE<br>DATE                                       |
| D 276                    | revealed: -There was an entry 100unit/mL, check if and inject per sliding-The entry for 6:30a medication aide that There was no space insulin administered. There was no entry implemented before lit could not be detainsulin was administ sliding scale from 0.  Review of Resident revealed: -There was an entry 100unit/mL, check if and inject per sliding-The entry for 6:30a the initials of the meadministered the might in the was no space resultThere was no space insulin administered. There was no entry implemented before lit could not be detainsulin was administ sliding scale from 0.  Review of signed pl 06/26/19 revealed to discontinue sliding seale from 0. | y for Novolog insulin fingerstick blood sugar (FSBS) g scale at 6:30am. Immincluded the initials of the administered the medication. The to document the FSBS to to document the units of the defended of the elunch, dinner, or bedtime. For the Novolog order to be the lunch, dinner, or bedtime. For the following for the resident per the 5/01/19-05/31/19 at 6:30am.  If #3's June 2019 eMAR of the following fingerstick blood sugar (FSBS) g scale for 6:30am. Immincluded an entry include redication aide that redication aide that redication. The to document the units of the following fingers of the Novolog order to be a lunch, dinner, or bedtime. For the Novolog order to be a lunch, dinner, or bedtime. For the Novolog order to be a lunch, dinner, or bedtime. For the following fingers order dated how many units of the tered to the resident per the following fingers order dated here was an order to scale insulin. | D 276               | Continued from page 80  Facility Medication Aide staff have training on Medication Administral Facility Medication Aide staff have been in-serviced on Job Descriptifications are treatments in accordance with phyorders  Facility staff have recieved docume training by a Licensed RN and ED Facility staff have been trained on "NPO" and Clear Liquid Diets by a Licensed RN | tion e on with nd ysicians nentation | 7/25/19<br>8/15/19<br>8/22/19<br>8/15/19<br>8/23/19<br>8/23/19 |
|                          | outside pharmacy d  | on 07/29/19 at 12:41 pm   |                     |   |                                      |  |

STATE FORM

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|---|---|--|-------------------------------|--------------------------|
|                          |  | HAL060149   | B. WING                                 |  | 07/2                          | 9/2019                   |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET ADI  | ORESS, CITY, S                          | STATE, ZIP CODE  |                               |                          |
| EAST TO                  | WNE  |   | TH SHAROI<br>TE, NC 282                 | N AMITY ROAD<br>205  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE.                         | (X5)<br>COMPLETE<br>DATE |
| D 276                    | revealed: -The pharmacy recestiding scale insulin-The pharmacy had 3mL insulin pens or Review of Resident revealed: -FSBS were record 05/01/19-06/17/19In May 2019, Resident (FSBS) rang-In June 2019, Resident (FSBS) rang-In | eived an order for Novolog on 12/28/18. I dispensed one box of five of 01/22/19 and 06/21/19. #3's vital signs report ed daily at various times from dent #3's fingerstick blood ged 122mg/dL-337mg/dL. ident #3's FSBS ranged  port dated 06/17/19 for ed upon arrival at the facility blood glucose level of 60  rge summary from a local of the facility of the dated 06/20/19 revealed: dmitted to the hospital on mary diagnosis of the facility from the facility blood glucose level of 60  rge summary from a local of the facility | D 276                                   |  |                               |                          |

| MAME OF PROVIDER OR SUPPLIER  EAST TOWNE  STREET ADDRESS, CITY, STATE, ZIP CODE  4816 NORTH SHARON AMITY ROAD CHARLOTE, N. C. 28205  PRICE OF CHARLOTE, N. C. |        | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |              | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY   |
|---|--------|--|---|--------------|---|-------------------|----------|
| ### A 1815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28206    A 1910  | ·      |  | HAL060149   | B. WING      |   | 07/2              | 29/2019  |
| Company   Comp  |        |  | 4815 NOF  | RTH SHARON   | AMITY ROAD  |                   |          |
| Interview with Resident #3 on 07/24/19 at 12:50pm revealed:  -His blood sugars were taken by the staff at the facility.  -He could not remember when or how often his blood sugars were taken when he was ordered sliding scale insulin.  Interview with a lead medication aide (MA) on 07/24/19 at 3:53pm revealed:  -On 06/17/19, "in the morning" she observed Resident #3 leaning on one side, unable to walk straight, she checked his blood sugar and it was "good".  -She could not remember what Resident #3's blood sugar was when she initially checked it on 06/17/19, she did not document.  -Resident #3 refused to go to the emergency room initially, therefore she assisted the resident to his room.  -On 06/17/19, "a little before lunch" she went to check on Resident #3, his communication was limited, she then called the paramedics and sent the resident to the hospital for further observation.  -She did not recall giving Resident #3 his insulin on 06/17/19 before he went to the hospital.  -When Resident #3 was ordered sliding scale insulin, there was not a place on the eMAR to record the BS or the number of units administered.  -She notified the Resident Care Coordinator (RCC) and the Director of Resident Care (DRC) and nothing was done.  | PREFIX | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL  | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO | LD BE             | COMPLETE |
| -She could not remember when she notified the RCC and DRCThe DRC said to "give us time to get it done".  Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:05am revealed: -She became the RCC on 07/08/19  | D 276  | Interview with Residal 2:50pm revealed: -His blood sugars we facilityHe could not reme blood sugars were a sliding scale insulin.  Interview with a lead 07/24/19 at 3:53pm -On 06/17/19, "in the Resident #3 leaning straight, she checked "good"She could not reme blood sugar was who 6/17/19, she did not resident #3 refuse room initially, therefore to his roomOn 06/17/19, "a little check on Resident; limited, she then cathe resident to the head on 06/17/19 before -When Resident #3 insulin, there was not record the BS or the administeredShe notified the Resident #3 insulin, there was not record the BS or the administeredShe notified the Resident #3 insulin, there was not record the BS or the administeredShe notified the Resident #3 insulin, there was not record the BS or the administeredShe notified the Resident #3 insulin, there was not record the BS or the administeredShe notified the Resident #3 insulin, there was not record the BS or the administeredShe notified the Resident #3 insulin, there was not record the BS or the administeredShe notified the Resident #3 insulin, there was not record the BS or the administeredShe notified the Resident #3 insulin, there was not record the BS or the administeredShe notified the Resident #3 insulin, there was not record the BS or the administeredShe notified the Resident #3 insulin, there was not record the BS or the administeredShe notified the Resident #3 insulin, there was not record the BS or the administered. | dent #3 on 07/24/19 at were taken by the staff at the mber when or how often his taken when he was ordered d medication aide (MA) on revealed: we morning" she observed g on one side, unable to walk ed his blood sugar and it was ember what Resident #3's nen she initially checked it on ot document. ed to go to the emergency fore she assisted the resident le before lunch" she went to #3, his communication was alled the paramedics and sent nospital for further observation. giving Resident #3 his insulin he went to the hospital. was ordered sliding scale of a place on the eMAR to e number of units esident Care Coordinator ctor of Resident Care (DRC) one. ember when she notified the give us time to get it done".  desident Care Coordinator at 10:05am revealed: |              |   |                   |          |

| Division of Health Service Regulation |  |   |                         | I OI (W)   | ALLINOVED         |                          |
|---------------------------------------|--|---|-------------------------|--|-------------------|--------------------------|
|                                       | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                         | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|                                       |  | HAL060149   | B. WING                 |  | 07/2              | 9/2019                   |
| NAME OF                               | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S          | STATE, ZIP CODE  |                   |                          |
| EAST TO                               | OWNE   |   | TH SHAROI<br>TE, NC 282 | N AMITY ROAD<br>205  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG              | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| D 276                                 | Continued From pa  | ge 83   | D 276                   |  |                   |                          |
|                                       | Resident #3 was or parameters were no was entered.  -The parameters we in the eMAR system appear on the eMA Interview with the let Resident Care Coo 10:48am revealed:  -She was the RCC -She approved the the eMAR system for the eMAR system for the corporate nursinto the eMAR system.  - "No one explained asystem.  - There was no product it".  -There was no product it".  -There was no product it in the Reprimary care provided 107/25/19 at 10:25ar  -The PCP expected administered the Nordord prevent hypoglycem. If Novolog was not Resident #3's blood could cause the resheadaches, and contact it in the resheadaches, and contact in the system. | ead medication aide/previous redinator (RCC) on 07/24/19 at until 07/08/19.  Novolog sliding scale order in or Resident #3.  the sliding scale units for the necked in the eMAR system. It is egave her orders to enter em.  In the eMAR system to me". It is emanded to entered, "I would have ness to review the eMARs for easily to entered, "I would have ess to review the eMARs for easily to be entered to entered." I Resident #3 to be entered as ordered to entered as ordered a sugar would be high and eident to be more tired, |                         |  |                   |                          |

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B. WING \_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 276 D 276 Continued From page 84 -The lead MA was the previous RCC, however she did not receive training on the eMAR system and was asked to step down. -The RCC and the DRC were responsible for implementing parameters populated on the eMAR. -The eMARs were to be checked daily by the MAs, RCC, and the DRC and changes were to be made as needed. b. Review of a signed physician's orders dated 06/26/19 revealed there was an order with a start date of 08/03/18 for Metoprolol Tartrate (used to treat high blood pressure) 50mg twice daily, hold for systolic blood pressure less than 125. Review of Resident #3's May 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Metoprolol Tartrate 50mg twice daily hold for systolic blood pressure less than 125. -There was documentation the Metoprolol Tartrate was administered from 05/01/19-05/31/19. -There was no space for blood pressures to be documented on the eMAR. -There was no documentation that the resident's blood pressure was recorded from 05/01/19-05/31/19. Review of Resident #3's June 2019 eMAR revealed: -There was an entry for Metoprolol Tartrate 50mg twice daily hold for systolic blood pressure less -There was documentation the Metoprolol Tartrate was administered from

Division of Health Service Regulation

06/01/19-06/21/19.

-There was no space for blood pressures to be

Division of Health Service Regulation

TATEMENT OF DEFICIENCIES TO PROVIDER/SUPPLIER/CLIA

|                          | OF CORRECTION  | IDENTIFICATION NUMBER:  |                            | CONSTRUCTION  |           | PLETED                   |
|--------------------------|--|---|----------------------------|---|-----------|--------------------------|
|                          |  | HAL060149   | B. WING                    |   | 07/       | 29/2019                  |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S             | TATE, ZIP CODE  | -         |                          |
| EAST TO                  | OWNE   |   | RTH SHARON<br>FTE, NC 2820 | AMITY ROAD<br>05  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| D 276                    | documented on the -There was no docu- blood pressure was 06/01/19-06/21/19.  Review of Resident Resident #3 from re -There were no doc from 05/01/19-06/19 -There were 4 blood 06/20/19-06/21/19.  Interview with a lead 07/24/19 at 3:53pm -She did not know was pressures were not always check his bl -She did not record if there was no space -There was no othe Resident #3's blood 05/01/19-06/21/19No one ever told he pressures anywhere Interview with the R (RCC) on 07/24/19 -She became the R -The parameters we in the eMAR system appear on the eMA -She noticed that the | eMAR.  umentation that the resident's recorded from  #3's vital signs report for evealed:  umented blood pressures  9/19. d pressures documented from  d medication aide (MA) on revealed: why Resident #3's blood listed on the eMAR, but "I cood pressure". blood pressures on the eMAR ce to document.  If place used to document if pressure from  er to document the blood e else.  Resident Care Coordinator at 10:05am revealed: ICC on 07/08/19. Itere not checked and initiated in therefore the orders did not R. Itere parameters were not | D 276                      |   |           |                          |
|                          | Interview with the le<br>Resident Care Coo<br>10:48am revealed:<br>-She was the RCC<br>-She did not realize  | eMAR and corrected it.  ead medication aide/previous rdinator (RCC) on 07/24/19 at  until 07/08/19. Ithe blood pressure of implemented on the eMAR.   |                            |   |           |                          |

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 276 Continued From page 86 D 276 -The corporate nurse gave her orders to enter into the eMAR system. -She did not have any training on the eMAR system. - "No one explained the eMAR system to me". -She did not know the parameters for the blood pressure parameters were not entered, "I would have fixed it". -There was no process to review the eMARs for accuracy. Interview with the registered nurse (RN) for the primary care provider (PCP) for Resident #3 on 07/25/19 at 10:25am revealed: -The PCP would expect the blood pressure to be checked prior to administering Metoprolol Tartrate. -The Metoprolol Tartrate was to be held if the systolic blood pressure is less than 125. -If the Metoprolol Tartrate was administered and the systolic blood pressure was lower than 125, the resident's blood pressure would drop too low and cause the resident to experience "dizziness and could cause the resident to faint". Interview with the Administrator on 07/25/19 at 4:20pm revealed: -The lead MA was the previous RCC, however she did not receive training on the eMAR system and was asked to step down. -The RCC and the DRC were responsible for implementing parameters populated on the eMAR. -The eMARs were to be checked daily by the MAs, RCC, and the DRC and changes were to be

Division of Health Service Regulation

made as needed.

2. Review of Resident #1's current FL-2 dated

01/16/19 revealed diagnoses included schizophrenia and type 2 diabetes mellitus.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING:  |                         | (X3) DATE SURVEY<br>COMPLETED   |       |                          |
|---|---|--|-------------------------|---|-------|--------------------------|
|   |   |  | , w bolability          |   |       |                          |
|   |   | HAL060149  | B. WING                 |   | 07/2  | 9/2019                   |
| NAME OF   | PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, S          | TATE, ZIP CODE  |       |                          |
| EAST TO   | OWNE  |  | TH SHARON<br>TE, NC 282 | I AMITY ROAD  |       |                          |
|   | CUMMADVETA  | TEMENT OF DEFICIENCIES   |                         | PROVIDER'S PLAN OF CORRECTI   | ON    | (VE)                     |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE | (X5)<br>COMPLETE<br>DATE |
| D 276   | Continued From pa   | ge 87  | D 276                   |   |       |                          |
|   |   |  |                         |   |       |                          |
|   | sheet from the GI of<br>-The date of the pro-<br>crossed out with the<br>handwritten beside<br>-There was a hand  |  |                         |   |       |                          |
|   | physician on 07/24/<br>-Resident #1 had b<br>colonoscopy by her<br>-He saw Resident #<br>04/12/19 and she c<br>stool and bloating.<br>-Resident #1 had a<br>removed approxima<br>-He scheduled Res<br>05/06/19.<br>-Resident #1 was a | ident #1 for a colonoscopy on<br>"no show" to the 05/06/19<br>ntment and was rescheduled         |                         |   |       |                          |
|   | -Resident #1 was a colonoscopy appoir for a colonoscopy appoir -Resident #1 was a colonoscopy appoir -Patients undergoir certain instructions the colonoscopyThese instructions liquid diet the day p                                 | n "no show" to the 05/20/19 Introduced was rescheduled on 07/15/19. In "no show" to the 07/15/19 |                         |   |       |                          |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING:   |                         | (X3) DATE SURVEY<br>COMPLETED  |       |                          |
|--|--|---|-------------------------|--|-------|--------------------------|
|  |  | HAL060149   | B. WING                 |  | 07/2  | 9/2019                   |
| NAME OF I  | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, 5          | STATE, ZIP CODE  |       |                          |
| EAST TO  | WNE  |   | TH SHAROI<br>TE, NC 282 | NAMITY ROAD<br>205   |       |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |
| D 276  | the day prior and ur have nothing to eat to the colonoscopy.  -These written instrutransportation drive the day of Resident faxed to the facility show" to her colonoscopy to verk instructions.  -Facility 2 days procolonoscopy to verk instructions.  -Facility staff reported bring Resident #1 to colonoscopy appoin administer her bower and Resident #1 was breakfast the mornicolonoscopies.  -It was very important residents were administructions. "The residents were administructions." The resident was very important residents were administructions. "The resident was very important the stool, and blocolon polyps at president for another at the facility could a responsibility for foll preparation instruct be required to have appointment.  a. Review of Resident. | atil after the colonoscopy, and after midnight the night prior uctions were provided to the r and faxed to the facility on #1's initial consultation and every day that she was a "no scopy appointments. Om his office also contacted for to each scheduled oally remind the staff of these ed to his office they did not to her three scheduled atments because they did not ell prep solution the day prior is also allowed to eat ing of the scheduled interest of the scheduled interest of the bowel prep ed the other colonoscopy esidents cannot do these history of colon polyps, blood ating she could have more sent or colon cancer. "We just to has the colonoscopy." I he would not reschedule the colonoscopy until someone assure him, they would take lowing through with the ions, and the resident would another consultation. | D 276                   |  |       |                          |
|  | Janumet 50/1000m   | n medication order for<br>g (an oral medication used to<br>one tablet once daily with   |                         |  |       |                          |

|                          | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|---|---|--|-------------------------------|--------------------------|
|                          |  | HAL060149   | B. WING                                 | B. WING  |                               | 9/2019                   |
| NAME OF                  | NAME OF PROVIDER OR SUPPLIER STREET ADI  |   |   | TATE, ZIP CODE   | •                             |                          |
| EAST TO                  | OWNE   |   | RTH SHARON<br>FTE, NC 282               | I AMITY ROAD<br>05   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| D 276                    | Continued From pa  | ge 89   | D 276                                   |  |                               |                          |
|                          | meals.   |   |   |  |                               |                          |
|                          | sheet from the GI d -"If you have diabet insulin or oral diabe your procedure." -On the day of the p please do not take diabetic medication after your procedure   | ·   |   |  |                               |                          |
|                          | Medication Adminis revealed: -There was an entry tablet to be adminis -There was no entry on the day prior to f colonoscopies (05/0-There was no entry on the days Reside colonoscopies (05/0-05/0-05/0-05/0-05/0-05/0-05/0-05/0 | #1's May 2019 Electronic tration record (eMAR)  y for Janumet 50/1000mg one tered daily at 8:00am. y to hold Janumet 50/1000mg Resident #1's scheduled 05/19 and 05/19/19). y to hold Janumet 50/1000mg nt #1 had scheduled 06/19 and 05/20/19). ng was administered 31 of 31 |   |  |                               |                          |
|                          | (07/01/19-07/23/19) -There was an entry tablet to be administed to be administed to the day prior to be colonoscopy (07/14) -There was no entry on the day Resident colonoscopy (07/15) -Janumet 50/1000n opportunities.         | y for Janumet 50/1000mg one stered daily at 8:00am. y to hold Janumet 50/1000mg Resident #1's scheduled //19). y to hold Janumet 50/1000mg t #1 had a scheduled   |   |  |                               |                          |

| Division of Health Service Regulation |  |   |                           |  |                               |                          |
|---------------------------------------|--|---|---------------------------|--|-------------------------------|--------------------------|
| STATEMEN                              | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | , ,                       | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|                                       |  | HAL060149   | B. WING                   |  | 07/2                          | 9/2019_                  |
| NAME OF                               | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S            | STATE, ZIP CODE  |                               |                          |
| EAST TO                               | OWNE   |   | RTH SHARON<br>TTE, NC 282 | NAMITY ROAD<br>05  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG              | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| D 276                                 | Continued From pa  | ge 90   | D 276                     |  |                               |                          |
| D 276                                 | 07/23/19 at 3:03pm -She did not know F scheduled for a cole -She did not know o put on hold for Resi Interview with a sec at 12:07pm reveale -She administered o days prior to and da colonoscopies beca entered onto the eN -"I only do what the -She had never beca medications or insu residents with color Interview with the R (RCC) on 07/25/19 -She had been the -The facility did not GI to be a physiciar -When instructions received from the G responsibility to con Care Provider (PCF diabetes medicatior -The PCP would re- medications and income | revealed: Resident #1 had ever been choscopy. If any time Janumet had been dent #1.  If and first shift MA on 07/25/19 d: Janumet to Resident #1 on any of her scheduled have there was no hold order MAR. If an told oral diabetes lin should be held for accopy appointments.  RCC since 07/08/19. If a consider instructions from the any of her scheduled for accopy appointments.  RCC since 07/08/19. If a consider instructions from the any of the RCC's accopy appointments.  If a consider instructions from the accopy appointments are accopy appointments.  RCC since 07/08/19. If a consider instructions from the accopy appointments are accopy appointments.  If a consider instructions from the accopy appointments are accopy appointments.  If a consider instructions from the accopy appointments are accopy appointments.  If a consider instructions from the accopy appointments are accopy appointments.  If a consider instructions from the accopy appointments are accopy appointments.  If a consider instructions from the accopy appointments are accopy appointments.  If a consider instructions from the accopy appointments are accopy appointments.  If a consider instructions from the accopy appointments are accopy appointments.  If a consider instructions from the accopy appointments are accopy appointments. | D 276                     |  |                               |                          |
|                                       | them temporarily.  -Once an order was RCC was responsible a new start date to administer the med -She did not work a #1's 05/06/19 and 0 colonoscopy appoir -She was the RCC   | t the facility during Resident<br>5/20/19 scheduled   |                           |  |                               |                          |

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 276 Continued From page 91 D 276 her diabetes medications had not been placed on -The colonoscopy instructions must have been received by the facility prior to her starting as the RCC. Telephone interview with Resident #1's GI physician's Medical Assistant on 07/25/19 at 11:22am revealed: -During Resident #1's initial consultation, the GI reviewed her blood sugar levels. -Resident #1 had blood sugar levels that were well controlled, so the GI instructed the facility to hold her diabetes medications because she was required to be on a clear liquid diet the day prior to the colonoscopy and NPO (nothing by mouth) the day of the colonoscopy. -If diabetes medications were not held for Resident #1 and she followed a clear liquid diet and NPO, there was a risk of her becoming hypoglycemic (having a low blood sugar level). Interview with the Administrator on 07/25/19 at 9:04am revealed: -She had worked at this facility for 3 weeks. -The RCC was responsible for assuring all instructions for colonoscopy preparation were followed by the MAs. -She provided oversight to the RCC. -She did not know Resident #1's Janumet had not been held as instructed by the GI. b. Review of Resident #1's colonoscopy instructions sheet from the GI dated 05/06/19 revealed: -The day before the colonoscopy, "All day, all liquids which include: broth, water, juices, tea soda, and Jell-O (nothing red in color and no milk or milk products)."

Division of Health Service Regulation

-"Nothing to eat or drink after midnight (the night

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B. WING \_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 276 D 276 | Continued From page 92 before your colonoscopy)." Review of Resident #1's progress notes revealed: -There was documentation of a late entry dated 05/21/19 Resident #1 "refused colonoscopy on 05/20/19. Resident made office visit aware that she has eaten breakfast, however told [facility] staff that she did not eat breakfast." -There was documentation dated 07/15/19 Resident #1's "appointment with IGI practice name! has been rescheduled due to resident being non-compliant and eating breakfast." Interview with Resident #1 on 07/23/19 at 10:10am revealed: -She missed a scheduled colonoscopy appointment the prior week. -She was not supposed to eat breakfast on the morning of her colonoscopy appointments, but she would sometimes forget and eat what was served to her in the dining room. Interview with Resident #1's Nurse Practitioner (NP) on 07/24/19 at 12:07pm revealed: -He had referred Resident #1 to the GI for a colonoscopy as a routine screening. -Resident #1 could not be expected to assure her own preparation for the colonoscopy especially with her psychiatric diagnoses. -The facility staff would have to monitor Resident #1 closely to assure she did not eat breakfast on the morning of the colonoscopy appointment. -The MAs should be responsible for assuring Resident #1 adhered to a clear liquid diet and did not eat breakfast.

Division of Health Service Regulation

Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:33pm revealed: -She had been the RCC since 07/08/19. -The RCC was responsible for printing

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 276 Continued From page 93 D 276 instructions regarding a resident not being allowed to eat breakfast and providing those instructions to the MAs and the Dietary Manager -She verbalized instructions regarding clear liquid diets to the MAs and the DM. -The DM was responsible for assuring residents on clear liquid diets were served appropriate liauids. -The DM was responsible for assuring residents who were NPO would not be served breakfast. -She did not work at the facility during Resident #1's 05/06/19 and 05/20/19 scheduled colonoscopy appointments. -Resident #1 missed her 07/15/19 colonoscopy appointment because she was not administered the bowel prep solution on 07/14/19 and because she ate breakfast on 07/15/19. Interview with the DM on 07/25/19 at 3:09pm revealed: -He had worked at this facility since 06/12/19. -He was only aware of one resident who had been on a clear liquid diet and NPO for a colonoscopy since he had worked at the facility. -The RCC had verbally communicated the information to him during a morning stand up meeting. -It was his and the other dietary staff's responsibility to assure the resident was not served breakfast. -He was never told Resident #1 was to be on a clear liquid diet or NPO.

Division of Health Service Regulation

9:04am revealed:

followed by the MAs.

Interview with the Administrator on 07/25/19 at

-The RCC was responsible for assuring all instructions for colonoscopy preparation were

-The Administrator or the RCC would

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|--|--|---|-------------------------------|--------------------------|
|                          |  | HAL060149  | B. WING                                  |   | 07/2                          | 9/2019                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY,                             | STATE, ZIP CODE   |                               | .0,2010                  |
| EAST TO                  | OWNE   |  | TH SHARO                                 | N AMITY ROAD  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | EACH DEFICIENCY  | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| D 276                    | communicate instrudiet orders and NPC -The DM was responsed to the colonosis breakfast the day of She provided overs-She was told Reside colonoscopy appoint to go and then ate to the state of the provided o | ictions regarding clear liquid D orders to the DM. Insible for assuring the donly clear liquids the day copy and was not served if the scheduled colonoscopy. Sight to both the RCC and DM. Hent #1 missed all three atments because she refused breakfast.  Item #8's current FL-2 dated diagnoses included and major depression.  #8's subsequent physician's 19 revealed an order for a creening with GI  #8's colonoscopy instructions ated May 2019 revealed: was crossed out with w' written beside it. The date the day being illegible | D 276                                    |   |                               |                          |

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING 07/29/2019 HAL060149 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 276 Continued From page 95 D 276 Attempted interview with Resident #8 on 07/25/19 at 3:43pm was unsuccessful. Telephone interview with Resident #8's GI physician's Medical Assistant on 07/25/19 at 11:22am revealed: -Resident #8 had been referred to GI for a colonoscopy by her Primary Care Provider (PCP). -Resident #8 had been seen by the GI on 04/12/19 for a consultation. -It was difficult for them to understand Resident #8 due to a language barrier, but as far as they could understand, she was not experiencing any symptoms but had never had a colonoscopy performed. -It was important for all residents to have a colonoscopy performed at least every 10 years beginning at age 50 and Resident #8 was over the age of 70. -Resident #8 was scheduled for a colonoscopy on 05/03/19. -Resident #8 was a "no show" to the 05/03/19 colonoscopy appointment and was rescheduled for a colonoscopy on 05/13/19. -Resident #8 was a "no show" to the 05/13/19 colonoscopy appointment and was rescheduled for a colonoscopy on 07/15/19. -Resident #8 was a "no show" to the 07/15/19 colonoscopy appointment. -Patients undergoing a colonoscopy had to follow certain instructions or else a colonoscopy could

Division of Health Service Regulation

not be performed.

-These instructions included adhering to a clear

liquid diet the day prior to the scheduled colonoscopy and have nothing to eat after midnight the night prior to the colonoscopy.

-These written instructions were provided to the transportation driver and faxed to the facility on the day of Resident #8's initial consultation and faxed to the facility every day that she was a "no

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 276 | Continued From page 96 D 276 show" to her colonoscopy appointments. -Representatives from their office also contacted the facility 2 days prior to each scheduled colonoscopy to verbally remind the staff of these instructions, -Facility staff reported to the GI office they did not bring Resident #8 to her three scheduled colonoscopy appointments because they did not administer her bowel prep solution the day prior and Resident #8 was also allowed to eat breakfast the morning of the scheduled colonoscopies. -After 3 "no shows," their office would not schedule residents for another colonoscopy until they had another consultation with the GI. -The GI was not willing to reschedule Resident #8 for another consultation until the facility could assure him, they would take responsibility for following the preparation instructions. Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:33pm revealed: -She had been the RCC since 07/08/19. -The RCC was responsible for printing instructions regarding a resident not being allowed to eat breakfast and providing those instructions to the MAs and the Dietary Manager (DM). -She verbalized instructions regarding clear liquid diets to the MAs and the DM. -The DM was responsible for assuring residents on clear liquid diets were served appropriate liquids.

Division of Health Service Regulation

#8's 05/03/19 and 05/13/19 scheduled

colonoscopy appointments.

-The DM was responsible for assuring residents who were NPO would not be served breakfast. -She did not work at the facility during Resident

-Resident #8 missed her 07/15/19 colonoscopy appointment because she was not administered

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 276 Continued From page 97 D 276 the bowel prep solution on 07/14/19 and because she ate breakfast on 07/15/19. Interview with the DM on 07/25/19 at 3:09pm revealed: -He had worked at this facility since 06/12/19. -He was only aware of one resident who had been on a clear liquid diet and NPO for a colonoscopy since he had worked at the facility. -The RCC had verbally communicated the information to him during a morning stand up meeting. -It was his and the other dietary staff's responsibility to assure the resident was not served breakfast. -He was never told Resident #8 was to be on a clear liquid diet or NPO. Interview with the Administrator on 07/25/19 at 9:04am revealed: -The RCC was responsible for assuring all instructions for colonoscopy preparation were followed by the MAs. -The Administrator or the RCC would communicate instructions regarding clear liquid diet orders and NPO orders to the DM. -The DM was responsible for assuring the resident was served only clear liquids the day prior to the colonoscopy and was not served breakfast the day of the scheduled colonoscopy. -She provided oversight to both the RCC and DM. The facility failed to implement physicians' orders for Resident #3 related to blood pressure checks, sliding scale insulin administration and finger stick blood sugar checks which resulted in a four day

Division of Health Service Regulation

hospitalization for hypoglycemia and

encephalopathy; for Resident #1 who had blood in the stool, stomach bloating and a history of

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 276 Continued From page 98 D 276 colon polyps, and was ordered a clear liquid diet, no breakfast and to hold Janumet (diabetes medication) for colonoscopy preparation resulting in her missing 3 of 3 consecutive appointments for scheduled colonoscopies; and for Resident #8 who had orders for a clear liquid diet and no breakfast for colonoscopy preparation which resulted in her also missing 3 of 3 consecutive appointments for scheduled colonoscopies. The failure of the facility to assure implementation of physicians' orders resulted in serious physical harm and neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 07/26/19 CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 26. 2019. D 344 10A NCAC 13F .1002(a) Medication Orders D 344 10A NCAC 13F .1004(a) Medication Orders 10A NCAC 13F .1002 Medication Orders Facility will assure contact with the resident's (a) An adult care home shall ensure contact with physician or prescribing practitioner for 8/26/19 the resident's physician or prescribing practitioner verification or clarification of orders, for verification or clarification of orders for All verification or clarification of orders will be medications and treatments: documented in residents record. (1) if orders for admission or readmission of the Facility has complete audits of residents 8/26/19 resident are not dated and signed within 24 hours physician orders and charts. of admission or readmission to the facility: (2) if orders are not clear or complete; or Senior VP of Clinical Services initiated a team of experienced Resident Care Directors 8/21/19 (3) if multiple admission forms are received upon admission or readmission and orders on the which have completed a audit of all eMARs forms are not the same. and Physicians Order. The facility shall ensure that this verification or clarification is documented in the resident's record.

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 344 Continued From page 99 D 344 Continued from page 99 Facility ED, RCC, DRC and/or Designee 8/26/19 will be responible for contactiting residents Perscribing Physician for verification or claification of order. Documentation of any contact with residents This Rule is not met as evidenced by: 8/26/19 prescribing physician will be documented in Based on observations, interviews, and record residents record. reviews the facility failed to ensure contact with the resident's physician for clarification of orders Facility ED, RCC, DRC and/or Designee for 1 of 12 residents regarding instructions to hold 8/26/19 will conduct ramdom chart reviews to an oral diabetic medication (Resident #1). monitor for documentations with presccribing physicians. Review of Resident #1's current FL-2 dated 01/16/19 revealed: 7/25/19. Facility Medication Aide staff have - Diagnoses included schizophrenia and type 2 8/15/19 received training on Medication diabetes mellitus. 8/22/19 Administation, job duties, clarification -There was a medication order for Janumet of orders 50/1000mg (an oral medication used to treat Facility staff have received training on diabetes) take one tablet once daily with meals. 8/23/19 documentation. Review of Resident #1's colonoscopy instructions sheet from the gastroenterologist (GI) dated 05/06/19 revealed: -"If you have diabetes, please do not take your insulin or oral diabetic medication the day before your procedure." -On the day of the procedure, "If you are diabetic, please do not take your morning insulin or oral

Division of Health Service Regulation

diabetic medications. Bring it with you and take

Telephone interview with Resident #1's GI physician on 07/24/19 at 9:41am revealed:
-Resident #1 had been referred to GI for a colonoscopy by her Primary Care Provider (PCP).

-Resident #1 had been seen by the GI on

-Patients undergoing a colonoscopy had to follow certain instructions or else a colonoscopy could

after your procedure is completed.

04/12/19 for a consultation.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 344 | Continued From page 100 D 344 not be performed. -These instructions included holding of their diabetes medications the day prior to and the day of a scheduled colonoscopy appointment. -These written instructions were provided to the transportation driver and faxed to the facility on the day of Resident #1's initial consultation on 04/12/19, and faxed to the facility again on 05/06/19, 05/20/19 and 07/15/19. -Representatives from their office also contacted the facility 2 days prior to each scheduled colonoscopy to verbally remind the staff of these instructions. Telephone interview with Resident #1's GI physician's Medical Assistant on 07/25/19 at 11:22am revealed: -During Resident #1's initial consultation, the GI reviewed her blood sugar levels. -Resident #1 had blood sugar levels that were well controlled, so the GI instructed the facility to hold her diabetes medications because she was required to be on a clear liquid diet the day prior to the colonoscopy and NPO (nothing by mouth) the day of the colonoscopy. -If diabetes medications were not held for Resident #1 and she followed a clear liquid diet and was NPO, there was a risk of her becoming hypoglycemic (having a low blood sugar level). Review of Resident #1's May 2019 Electronic Medication Administration record (eMAR) revealed: -There was an entry for Janumet 50/1000mg one tablet to be administered daily at 8:00am. -There was no entry to hold Janumet 50/1000mg on the day prior to Resident #1's scheduled colonoscopies (05/05/19 and 05/19/19), -There was no entry to hold Janumet 50/1000mg on the days Resident #1 had scheduled

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ B. WING\_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE. (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 344 D 344 Continued From page 101 colonoscopies (05/06/19 and 05/20/19). -Janumet 50/1000mg was documented as administered 31 of 31 opportunities. Review of Resident #1's July 2019 eMAR (07/01/19-07/23/19) revealed: -There was an entry for Janumet 50/1000mg one tablet to be administered daily at 8:00am. -There was no entry to hold Janumet 50/1000mg on the day prior to Resident #1's scheduled colonoscopy (07/14/19). -There was no entry to hold Janumet 50/1000mg on the day Resident #1 had a scheduled colonoscopy (07/15/19). -Janumet 50/1000mg was documented as administered 23 of 23 opportunities. Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:33pm revealed: -The facility did not consider instructions from the GI to be a physician's order. -When instructions for colonoscopies were received from the GI, it was the RCC's responsibility to contact the resident's Primary Care Provider (PCP) to obtain an order to hold diabetes medications. -It was the RCC's responsibility to fax referrals made by the Primary Care Provider (PCP) to outside providers and schedule the appointments. -The PCP would review all the residents' medications and indicate which medications were for diabetes and would order the ones that needed to be held. -Once an order was received from the PCP, the RCC was responsible for adding a stop date and

Division of Health Service Regulation

07/15/19 colonoscopy.

a new start date to the eMAR so medication aides (MA) would not administer the medications. -She did not know why Resident #1's diabetes medications had not been placed on hold for her

6899

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED                                |                                      |
|--------------------------|--|---|--|---|--|--------------------------------------|
|                          |  | HAL060149   | B. WING                                  |   | 07/29/2019   |                                      |
| NAME OF                  | PROVIDER OR SUPPLIER   | <u> </u>  | DRESS, CITY, :                           | STATE, ZIP CODE   | 0172   | 5/2015                               |
| EAST TO                  | NAME   |   |  | N AMITY ROAD  |  |                                      |
|                          |  |   | TE, NC 282                               | 205   |  |                                      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   |  |                                      |
| D 344                    | Continued From pa  | ge 102  | D 344                                    |   |  |                                      |
|                          |  | ide any documentation the ed to clarify the instructions PCP.   |  |   |  |                                      |
|                          | Attempted telephone interview with Resident #1's PCP on 07/29/19 at 10:35am was unsuccessful.  Interview with the Administrator on 07/25/19 at 9:04am revealed: -The RCC was responsible for assuring all instructions for colonoscopy preparation were followed by the MAsShe provided oversight to the RCCShe did not know Resident #1's Janumet had not been held as instructed by the GI.  CORRECTION DATE FOR THE STANDARD DEFICIENCY SHALL NOT EXCEED SEPTEMBER 1, 2019. |   |  |   |  |                                      |
| D 358                    |  |   | D 358                                    | 10A NCAC 13F .1004(a) Medication Administration Facility management will assure th  |  |                                      |
|                          | <ul> <li>(a) An adult care he preparation and adresscription and not by staff are in accord) orders by a licely which are maintained</li> </ul>  | O4 Medication Administration ome shall assure that the ministration of medications, n-prescription, and treatments dance with: nsed prescribing practitioner ed in the resident's record; and ction and the facility's policies |  | preparation and administration of medications and/treatments by staff are in accordar orders by licensed practitioner and policies and procedures  Facility has completed audits on all resident charts.  Senior VP of Clinical Services initiateam of experianced Resident Care Directors which have completed an all EMARS and Physicians Orders ensure accuray | or<br>nce with<br>I the facilit<br>ated a<br>e<br>n audit of | 8/26/19<br>y's<br>8/26/19<br>8/21/19 |
|                          |  |   |  |   |  |                                      |

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ HAL060149 B. WING 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD **EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) D 358 D 358 Continued From page 103 Continued from page 103 Facility pharmacy has conducted an On-site Medication cart audit of all medications 8/22/19 Facility RCC and/ or Lead SIC This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE A2 will continue to complete weekly medication cart audits. Documentation VIOLATION 8/26/19 of cart audits will be noted on tracking form. Tracking form will be signed by person Based on these findings, the previously Unabated completing cart audits. A2 Violation has not been abated. Non-compliance continues with increased Medication Cart audits and tracking form severity resulting in serious physical harm. 8/26/19 will be reviewed by RCC, DRC and/or ED weekly for one month then ramdonly there THIS IS A TYPE A1 VIOLATION Based on observations, interviews, and record Facility has reorganized and cleaned 8/26/19 reviews, the facility failed to assure medications med room and medication carts. were administered as ordered by a licensed prescribing practitioner for 2 of 5 residents Facility RCC and/or DRC will review and approve all medication orders prior to observed during a medication pass related to a 8/26/19 implemention and/or administration muscle relaxant and an anti-seizure medication (Residents #10 and #11) and 5 of 8 sampled Facility ED, RCC, DRC and/or designee residents (Residents #1, #3, #4, #8 and #13) will randomly audit/review eMARs and 8/26/19 including a medication used to clean the colon physician orders for accurancy prior to a colonoscopy (Residents #1 and #8), a medication used to lower high cholesterol, a Facility ED. RCC. DRC and/or Licensed medication used to treat high blood pressure, and Health Professional will complete 8/26/19 artificial tears for dry eyes (Resident #3), a Medication Pass Observation no less than medication used to treat diabetes and two three times monthly, then no less than medications used to prevent difficulty in breathing

Division of Health Service Regulation

#13).

The findings are:

(Resident #4), a medication used as a muscle

relaxant (Resident #10), a medication used to

and a medication used for agitation (Resident

The medication error rate was 6% based on the observation of 2 errors out of 33 opportunities during the 8:00am medication pass on 07/24/19.

treat seizures and bipolar disorder (Resident #11)

monthly and ramdonly there after.

have conducted weekly audits during

Services and/or Divisional VP of Operations

Divisional Director of Clincial

scheduled visits

8/26/19

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|---|---|--|-------------------------------|--------------------------|
|   |  |   | B. WING   |  | 07/00/0040                    |                          |
| <del></del>   | <u> </u>   | HAL060149   | D. VVING  | ***************************************  | 07/2                          | 9/2019                   |
| NAME OF I   | PROVIDER OR SUPPLIER   |   |   | STATE, ZIP CODE  |                               |                          |
| EAST TO   | WNE  |   | TH SHAROI<br>TE, NC 282   | N AMITY ROAD<br>205  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | .D BE                         | (X5)<br>COMPLETE<br>DATE |
| D 358   | Continued From pa  | ge 104  | D 358   | Continued from page 103  |                               |                          |
|   | 01/17/19 revealed  | ent #10's current FL2 dated<br>diagnoses included cerebral<br>sion and hemiplegia and   |   | Facility Medication Aides have red<br>immedate training on Medication<br>Administration, training conducted<br>Licensed RN                                       |                               | 7/25/19,<br>8/15/19      |
|   | Review of Resident #10's signed physician's orders dated 06/05/19 included Cyclobenzaprine (a muscle relaxant) 5mg take 1 tablet twice daily.  Review of Resident #10's July 2019 electronic Medication Administration Record (eMAR) revealed there was an entry for Cyclobenzaprine 5mg to be administered at 8:00am and 8:00 pm. |   | dated 06/05/19 included Cyclobenzaprine cle relaxant ) 5mg take 1 tablet twice daily. | Facility Medication Aides have recieved training by a Licensed RN on: Resident Rights and Med Adminstration Medication Error Reporting Review of Job Description |                               | 8/15/19                  |
|   |  |   |   | Facility Medication Aides have rec<br>training on facility Policies and<br>Procedures including Medication I<br>and Procedures                                   |                               | 8/20/19 &<br>8/22/19     |
|   | 8:00am medication<br>-The Medication Ai  | rvation on 07/24/19 at 7:48am of the m medication pass revealed:  Medication Aide (MA) consulted the eMAR uter monitor prior to administering the |   | Facility Medication Aides have rece<br>training on Medication Administration<br>facility's pharmacy  |                               | 8/22/19                  |
|   | medicationsThe MA prepared 1 nasal spray to Re -The MA document "administered" afte tablets and the nas -Cyclobenzaprine 8   | and administered 7 tablets and  |   | Facility staff have received training proper documentation   | on                            | 8/23/19                  |
|   | medications on ha  | /24/19 at 9:03am of the<br>nds for Resident #10 revealed<br>mg was not available on the<br>administering.   |   |  |                               |                          |
|   | 9:05am revealed: -Resident #10 was two times dailyShe had initialed a  | day shift MA on 07/24/19 at<br>ordered Cyclobenzaprine 5mg<br>as administering<br>mg to Resident #10 on   |   |  |                               |                          |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|--|-------------------------|--|-------------------------------|--------------------------|
|   |  | HAL060149  | B. WING                 |  | 07/2                          | 9/2019                   |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S          | STATE, ZIP CODE  |                               |                          |
| EAST TO   | DWNE   |  | TH SHARON<br>TE, NC 282 | NAMITY ROAD<br>05  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| D 358   | 07/24/19 at 8:00am -She was not sure of the was not sure of the medication cartThe Cyclobenzapy when the medication cartThe medication is -The medication is -The medication is -The medication of the medications on 07/2-She thought she had medications on 07/2-She denied pain of the medications as ord  Observation of the in the medication as ord  Observation of the in the medication for revealed there were Cyclobenzaprine of Resident #10 in the Interview with the F(RCC) on 07/24/19 -She did not know of documented as add 07/24/19 at 8:00am available on the medication carts with for the residentsThe lead MA was in MA and assuring the for administering to -The MAs were to residents were to residents were to residents. | why she documented on the prine 5mg as administered on was not administered. In the same and administered on was not administered. In the same as a discomplete on the administer to Resident #10. In probably in our overstock." It the administered by mistake." It dent #10 on 07/24/19 at additional received all her 24/19 at 8:00am. In the administer her ered by the physician.  It is the same as a | D 358                   |  |                               |                          |

Division of Health Service Regulation

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|---|---|---|--|-------------------------------|--------------------------|
|                          |   |   | A. BOILDING.                            |  |                               |                          |
|                          |   | HAL060149   | B. WING                                 |  | 07/2                          | 29/2019                  |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |   | STATE, ZIP CODE  |                               |                          |
| EAST TO                  | OWNE  |   | TH SHARON<br>TTE, NC 282                | N AMITY ROAD   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETE<br>DATE |
| D 358                    | Continued From pa   | ge 106  | D 358                                   |  |                               |                          |
|                          | 01/17/19 revealed: -Diagnoses include and unspecified col -Physician orders ir (anticonvulsant use times daily.   | ncluded Lamotrigine<br>and to treat seizures) 200mg two   |   |  |                               |                          |
|                          | Medication Adminis revealed there was   | :#11's July 2019 electronic<br>tration Record (eMAR)<br>an entry for Lamotrigine<br>istered at 8:00am and 8:00                              |   |  |                               |                          |
|                          | 8:00am medication -The Medication Aid computer monitor p medicationsThe MA prepared a Resident #11The MA document "administered" after tablets to Resident -Lamotrigine 200mg | de (MA) consulted the eMAR prior to administering the and administered 7 tablets to ed by initials on the eMAR rishe had administered the 7 |   |  |                               |                          |
|                          | medications on har  | 24/19 at 9:03am of the<br>ids for Resident #11 revealed<br>was not available on the<br>administering.                                       |   |  |                               |                          |
|                          | 9:05am revealed:<br>-Resident #11 was<br>two times daily.<br>-She had initialed a   | ay shift MA on 07/24/19 at<br>ordered Lamotrigine 200mg<br>nd documented "Cycle" on the<br>ine 200mg for Resident #11 on                    |   |  |                               |                          |

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 107 D 358 D 358 07/24/19 at 8:00am. -The Lamotrigine 200mg was not available on the medication cart to administer to Resident #11. -"The medication is probably in our overstock." -The facility is on "cycle fill" which meant we never run out of the medications for the residents. -She did not have time to pull the overstock medications for Resident #11 prior to 06/24/19 at 8:00am. -The overstock medications were located in the medication room. -The MAs were responsible for stocking the medication carts and pulling the resident's medications from the overstock. -'I should had went and got the medication for Resident #11." -"I do not have time to go the med room during my morning med pass and check for the medications in the overstock." Interview with Resident #11 on 07/24/19 at 8:50am revealed: -She thought she had received all her medications on 07/24/19 at 8:00am. -The MA did not explain she had not received all her morning medications at 8:00am. -She denied seizure activity. -She relied on the facility staff to administer her medications as ordered by the physician. Observation of the overstock "cycle bins" located in the medication room on 07/24/19 at 10:42am revealed there were 56 tablets of lamotrigine

Division of Health Service Regulation

the overstock bin.

200mg dispensed on 07/14/19 for Resident #11 in

Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 11:40am revealed: -She did not know lamotrigine 200mg was documented as "cycle" to Resident #11 on

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B. WING \_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) IO (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 358 D 358 Continued From page 108 07/24/19 at 8:00am when the medication was not available on the medication cart. -The MA should retrieve the lamotrigine 200mg from overstock in the medication room and administer the medication on time. -The MA should not be charting "cycle" when the medication was available in overstock. 3. Review of Resident #1's current FL-2 dated 01/16/19 revealed diagnoses included schizophrenia and type 2 diabetes mellitus. Review of Resident #1's physician's orders dated 05/06/19 revealed a medication order from her GI (gastroenterologist) for GoLytely (a medication used to cleanse the colon prior to a colonoscopy) oral solution reconstituted; use as directed for bowel prep. Review of Resident #1's medical or emergency referral form revealed the facility had requested an order from Resident #1's Nurse Practitioner (NP) on 05/20/19 for "GaviLyte-G (a mediation used to cleanse the colon prior to a colonoscopy) to have colonoscopy done" and the NP had signed the order on 05/22/19. Review of Resident #1's colonoscopy instructions sheet from the GI dated 05/06/19 revealed: -The date of the procedure (05/06/19) was crossed out with the words "No Show" handwritten beside it. -There was a handwritten note documenting Resident #1 had a colonoscopy rescheduled for 07/15/19. Interview with Resident #1 on 07/23/19 at

Division of Health Service Regulation

10:10am revealed:

appointment the prior week.

-She missed a scheduled colonoscopy

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER: |   | 1 ' '   | E CONSTRUCTION            | COMPLETED   |        |                  |  |
|--|---|---|---------------------------|---|--------|------------------|--|
|  |   | LIAL GEOTAG   | B. WING                   |   | 07/0   | 07/29/2019       |  |
|  | ·   | HAL060149   | B. 11110                  |   | 07/2   | 29/2019          |  |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S            | STATE, ZIP CODE   |        |                  |  |
| EAST TO  | OWNE  |   | RTH SHARON<br>TTE, NC 282 | N AMITY ROAD<br>205   |        |                  |  |
| (X4) ID  | SUMMARY STA   | TEMENT OF DEFICIENCIES  | ID                        | PROVIDER'S PLAN OF CORREC   | TION   | (X5)             |  |
| PREFIX<br>TAG  |   |   | PREFIX<br>TAG             | (EACH CORRECTIVE ACTION SHOI<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE | COMPLETE<br>DATE |  |
| D 358  | Continued From pa   | ge 109  | D 358                     |   |        |                  |  |
| D 358  | -She missed the scappointment becaucould not locate her (GoLytely) she had colonoscopy appoir -The MA had asked and told Resident # locate her "drink" (G-She did not know i rescheduled.  Telephone interview physician on 07/24/-Resident #1 had be colonoscopy by her -He saw Resident # 04/12/19 and she colonoscopy by her -He saw Resident #1 had a removed approximal -He scheduled Res 05/06/19.  -Resident #1 was a colonoscopy of -Resident #1 was a colonoscopy appoir for a colonoscopy appoir for a colonoscopy appoir -Patients undergoin certain instructions the colonoscopy incof bowel prep solutions 5:00pm the evening -An order for GoLytines. | heduled colonoscopy se the Medication Aide (MA) r "drink with electrolytes" to take the day before the ntment. I another MA on duty that day 1 that neither of them could GoLytely). If her colonoscopy had been with Resident #1's Gl 19 at 9:41am revealed: een referred to him for a Primary Care Provider (PCP). If for a consultation on complained of blood in her history of colon polyps ately 9 years prior. ident #1 for a colonoscopy on "no show" to the 05/06/19 ntment and was rescheduled on 05/20/19. "no show" to the 05/20/19 ntment and was rescheduled on 07/15/19. "no show" to the 07/15/19 |                           |   |        |                  |  |
|  | faxed to the facility   | #1's initial consultation and<br>every day that she was a "no<br>escopy appointments.   |                           |   |        |                  |  |

Division of Health Service Regulation

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B. WING \_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 110 -A representative from his office also contacted the facility 2 days prior to each scheduled colonoscopy to verbally remind the staff of these instructions. -Facility staff reported to his office they did not bring Resident #1 to her three scheduled colonoscopy appointments because they did not administer GoLytely the day prior and Resident #1 was also allowed to eat breakfast the morning of the scheduled colonoscopies. -It was very important for facility staff to assure residents were administered GoLytely and followed the other colonoscopy instructions. "The residents cannot do these things themselves." -With Resident #1's history of colon polyps, blood in the stool, and bloating she could have more colon polyps at present or colon cancer. "We just don't know [until she has the colonoscopy]." -After 3 "no shows," he would not reschedule the resident for another colonoscopy until someone at the facility could assure him, they would take responsibility for following through with the preparation instructions, and the resident would be required to have another consultation appointment. Review of Resident #1's May 2019 Electronic Medication Administration Record (eMAR) revealed: -There was no entry for GoLytely to be administered on 05/05/19 prior to the 05/06/19 scheduled colonoscopy. -There was no entry for GoLytely to be administered on 05/19/19 prior to the 05/20/19 scheduled colonoscopy. -There was an entry for GaviLyte-G (generic for GoLvtely) to be administered at 8:00am on 05/23/19 with documentation it had not been administered.

Division of Health Service Regulation

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | l ' '               | E CONSTRUCTION   | (X3) DATE |                          |
|--------------------------|---|---|---------------------|--|-----------|--------------------------|
| AND FLAN                 | OF CORRECTION   | IDENTIFICATION NOMBER.  | A. BUILDING:        | <del></del>  | COMPLETED |                          |
|                          |   | HAL060149   | B. WING             |  | 07/2      | 9/2019_                  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |           |                          |
| EAST TO                  | WNE   |   | TH SHARON           | N AMITY ROAD<br>205  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE      | (X5)<br>COMPLETE<br>DATE |
| D 358                    | Continued From page 111  Review of Resident #1's July 2019 eMAR revealed there was an entry for the bowel prep solution GaviLyte-G to be administered at 5:00pm on 07/14/19 with documentation it had not been administered.  |   | D 358               |  |           |                          |
|                          |   |   |                     |  |           |                          |
|                          | Observation of Resident #1's medications available for administration on 07/25/19 at 12:07pm revealed an unopened container of GaviLyte-G solution with a dispense date of 05/22/19.  |   |                     |  |           |                          |
|                          | Telephone interview with a representative from the facility's contracted pharmacy on 07/24/19 at 9:06am revealed: -They had received only one order from the facility for Resident #1's GoLytelyThe GoLytely order was received on 05/22/19 and the pharmacy dispensed a one-time supply on the same day. |   |                     |  |           |                          |
|                          | pharmacy on 07/25<br>-The facility faxed p<br>pharmacy.   | e interview with a the facility's contracted /19 at 10:37am revealed: ohysician's orders to the ered the orders into the eMAR |                     |  |           |                          |
|                          | system.  -If the order provide would enter the me that dateIf the order did not   | ed a start date, the pharmacy<br>dication onto the eMAR for<br>provide a start date, the<br>ster the medication onto the      |                     |  |           |                          |
|                          | <ul> <li>If the physician's o<br/>to go into the eMAF<br/>it would populate or<br/>administration.</li> <li>The pharmacy ent</li> </ul>   | rder was new, the facility had<br>R system and approve it before  |                     |  |           |                          |

If continuation sheet 113 of 187

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: \_ B. WING 07/29/2019 HAL060149 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 112 (05/23/19) because it did not have a start date. -The facility had the ability to adjust dates and times of scheduled administration, if necessary, to coordinate administration of the GoLytely with the scheduled colonoscopy. Interview with a first shift MA on 07/24/19 at 11:45am revealed: -She had never administered GoLytely to Resident #1. -She had only seen GoLytely populated on the eMAR on one occasion for Resident #1 and that was on 05/23/19. -She asked the Lead MA/previous Resident Care Coordinator (RCC) if she should administer the GoLytely on 05/23/19 and she was told no that Resident #1 did not have a colonoscopy scheduled for the following day. Telephone interview with a second shift MA on 07/25/19 at 11:35am revealed: -She had never administered GoLytely to Resident #1. -She had only seen GoLytely populated on the eMAR on one occasion for Resident #1 and that was on 07/14/19. -She did not administer GoLytely to Resident #1 on 07/14/19 because she could not locate it in the facility. -She asked another MA if she knew where it was, and she could not locate it either. -She did not attempt to contact the pharmacy or a supervisor to help her locate the medication. Interview with the Lead MA/previous RCC on 07/24/19 at 12:49pm revealed: -She had worked at the facility since 04/16/19. -She transferred from another facility where she had worked in a Special Care Unit (SCU). -Processes were very different in the Assisted

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | , ,                 | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|---|--|---------------------|--|-------------------|--------------------------|
|                          |   | LIAI 000440  | B. WING             |  | 07/00/0040        |                          |
| NAME OF S                |   | HAL060149  |                     | DEATE TO CODE  | 1 07/2            | 9/2019                   |
|                          | PROVIDER OR SUPPLIER  |  |                     | STATE, ZIP CODE<br>NAMITY ROAD   |                   |                          |
| EAST TO                  | WNE   |  | TE, NC 282          |  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
| D 358                    | Continued From pa   | ge 113   | D 358               |  |                   |                          |
|                          | Living Facility (ALF) training on those privorking.  -She did not know for a colonoscopy on 0.  -Whomever receive given at Resident # should have faxed to given the colonoscopy on the colonoscopy on the colonoscopy on the colonoscopy on the colonoscopy of the colonoscopy on the | and she had received no ocesses when she began  Resident #1 was scheduled for 5/06/19.  Ed the order for the GoLytely 1's GI consult on 04/12/19  Ethe order to the pharmacy and opy date to the RCC who was ne.  It #1 had a colonoscopy 1/19 and thought she missed it aten breakfast that morning. Resident #1 was not ely on 05/19/19.  If why Resident #1's order for the 1/19/19 had not been sent to the could have been administered 05/20/19 colonoscopy 1/19.  If had a colonoscopy 1/19 if from Resident #1's NP on 1/19/19 already had an order from 1/19.  If #1 had a colonoscopy on the GoLytely was not 1/14/19.  If ministered on 07/14/19 if duty that day could not locate in though it was in the 1/14/19 to call her or another ould not locate a medication, |                     |  |                   |                          |

Division of Health Service Regulation

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 Continued From page 114 D 358 Interview with the RCC on 07/25/19 at 2:33pm revealed: -She had been the RCC since 07/08/19. -The RCC was responsible for faxing new orders to the pharmacy and approving those orders in the eMAR system after they were entered by the pharmacy. -She had the capability of adjusting dates and times of administration in the eMAR system if needed so medications such as GoLvtely could be administered based on the appointment date for the colonoscopy. -She did not work at the facility during Resident #1's 05/06/19 and 05/20/19 scheduled colonoscopy appointments. -Resident #1 missed her 07/15/19 colonoscopy appointment because she was not administered GoLytely on 07/14/19 and because she ate breakfast on 07/15/19. -Resident #1 was not administered GoLytely on 07/14/19 because the MA could not locate it even though it was in the medication room. -The MA should have contacted either her or the pharmacy to help her locate the medication, but she did not. Interview with the Administrator on 07/25/19 at 9:04am revealed: -She had worked at this facility for 3 weeks. -The RCC was responsible for sending orders to the pharmacy. -The pharmacy entered orders into a resident's computer profile.

Division of Health Service Regulation

the pharmacy.

-Once the medication was dispensed to the facility, it was the RCC's responsibility to verify and approve the order entered onto the eMAR by

based on the date of the colonoscopy

-The RCC was responsible for entering the date on the eMAR GoLytely should be administered

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_\_\_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 358 D 358 Continued From page 115 appointment. -The RCC was responsible for assuring all instructions for colonoscopy preparation, including GoLytely administration, were followed by the MAs. -She provided oversight to the RCC. -GoLvtely should not have been on the eMAR to be administered to Resident #1 on 05/23/19 because she did not have a colonoscopy scheduled for 05/24/19. -GoLytely should have been on the eMAR and available for administration on 05/05/19 and 05/19/19 for Resident #1. -She did not know the MA was unable to find the GoLytely in the medication room on 07/14/19, but she would have expected her to contact a supervisor for help. 4. Review of Resident #8's current FL-2 dated 01/16/19 revealed diagnoses included Parkinson's disease and major depression. Review of Resident #8's physician's orders dated 04/12/19 revealed a medication order from her GI (gastroenterologist) for GoLytely (a medication used to cleanse the colon prior to a colonoscopy) oral solution reconstituted; use as directed for bowel prep. Review of Resident #8's medical or emergency referral form revealed the facility had requested an order from Resident #1's Nurse Practitioner (NP) on 05/20/19 for "GaviLyte-G (a medication

used to cleanse the colon prior to a colonoscopy) to have colonoscopy done" and the NP had

Review of Resident #8's colonoscopy instructions sheet from the GI dated May 2019 revealed:
-The date of the procedure was crossed out with

signed the order on 05/22/19.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | ' '   | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |            |                          |
|--|--|---|---------------------|--|------------|--------------------------|
|  |  | HAL060149   | B. WING             |  | 07/29/2019 |                          |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET ADI  | ORESS, CITY, S      | STATE, ZIP CODE  |            |                          |
| EAST TO  | OWNE   |   |                     | NAMITY ROAD  |            |                          |
|  |  | CHARLO  | TE, NC 282          | 205  |            |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE      | (X6)<br>COMPLETE<br>DATE |
| D 358  | Continued From pa  | ge 116  | D 358               |  |            |                          |
| D 358  | the words "No Show was May 2019 with because it was crost-There was a hand. Resident #8 had a co5/13/19 with the wit.  -There was a hand. Resident #8 had a co7/15/19.  Attempted interview at 3:43pm was unsured interview with Resident at 3:43pm was unsured interview with Resident #8 had be colonoscopy by here. It was difficult for the was difficult for the was difficult for the was important for colonoscopy performed.  -It was important for colonoscopy performedIt was important for colonoscopy performedResident #8 was a colonoscopy appoint for a colonoscopy appoi | w" written beside it. The date the day being illegible ised through. written note documenting colonoscopy rescheduled for ords "No Show" written beside written note documenting colonoscopy rescheduled for with Resident #8 on 07/25/19 accessful.  Sent #8's GI physician's no 07/25/19 at 11:22am  Been referred to GI for a Primary Care Provider (PCP). Been seen by the GI on ultation. The mean to understand Resident ge barrier, but as far as they she was not experiencing any never had a colonoscopy or all residents to have a med at least every 10 years and Resident #8 was age 70. Cheduled for a colonoscopy on "no show" to the 05/03/19 of the of 13/19. "no show" to the 05/13/19 of the | D 358               |  |            |                          |
|  | colonoscopy appoir<br>-Patients undergoin  | ntment.<br>g a colonoscopy had to follow  |                     |  |            |                          |

| Division                 | of Health Service Re  | egulation  |                         |   | 1 OINW                                 | - TINOVLD                |
|--------------------------|---|--|-------------------------|---|--|--------------------------|
| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | E CONSTRUCTION  | (X3) DATE SURVEY COMPLETED  07/29/2019 |                          |
|                          |   | HAL060149  | B. WING                 |   |  |                          |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, 5          | STATE, ZIP CODE   |  |                          |
| EAST TO                  | OWNE  |  | TH SHARON<br>TE, NC 282 | NAMITY ROAD<br>205  |  |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO-<br>DEFICIENCY) | D BE                                   | (X5)<br>COMPLETE<br>DATE |
| D 358                    | not be performed in container of bowel starting at 5:00pm to colonoscopy.  An order for GoLyt transportation drive the day of Resident faxed to the facility show" to her colono-Representatives for the facility 2 days polonoscopy to vertinstructions.  Facility staff report bring Resident #8 to colonoscopy appoir administer her GoL Resident #8 was almorning of the sche-After 3 "no shows, schedule residents they had another colonoscopy appoir administer her GoL Resident #8 was almorning of the sche-After 3 "no shows, schedule residents they had another colonoscopy appoir administer her consults assure him, they we following the preparameter on OS scheduled colonoscopy. There was no entry administered on OS scheduled colonoscopy appoir administered on OS scheduled colonoscopy. There was an entry GoLytely) to be administered on OS scheduled colonoscopy. There was an entry GoLytely) to be administered on OS scheduled colonoscopy. | or else a colonoscopy could icluding drinking a full orep solution (GoLytely) the evening prior to the ely was provided to the r and faxed to the facility on #8's initial consultation and every day that she was a "no oscopy appointments. om their office also contacted rior to each scheduled oally remind the staff of these ed to the GI office they did not on their office would not great their office would not for another colonoscopy until onsultation with the GI. Iling to reschedule Resident #8 action until the facility could be possible to the colonoscopy until onsultation with the GI. It was also until the facility could be possible to the word of the colonoscopy until onsultation with the GI. It was also until the facility could be possible to the colonoscopy until onsultation with the GI. It was also until the facility could be possible to the colonoscopy until or reschedule Resident #8 action until the facility could be possible to the colonoscopy until or reschedule the colonoscopy until or reschedule the facility could be possible to the colonoscopy until or reschedule the facility could be possible to the colonoscopy until or reschedule the facility could be possible to the colonoscopy until or reschedule the facility could be possible to the colonoscopy until or reschedule the facility or reschedule the facility or reschedule the facility or reschedule the facility of the colonoscopy until or reschedule the facility or reschedule the facility of the colonoscopy until or reschedule the facility of the colonoscopy until or reschedule the facility | D 358                   |   |  |                          |

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                           | (X3) DATE SURVEY<br>COMPLETED  |                |                  |  |
|--|---|---|---------------------------|--|----------------|------------------|--|
|  |   |   | A. BUILDING.              |  |                |                  |  |
|  |   | HAL060149   | B. WING                   |  | 07/2           | 9/2019           |  |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S            | TATE, ZIP CODE   |                |                  |  |
| EAST TO  | WNE   |   | RTH SHARON<br>TTE, NC 282 | I AMITY ROAD<br>05   |                |                  |  |
| (X4) ID  | SUMMARY STA   | TEMENT OF DEFICIENCIES  | ID ID                     | PROVIDER'S PLAN OF CORRECT!  | ON             | (X5)             |  |
| PRÉFIX<br>TAG  |   | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG             | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE<br>PRIATE | COMPLETE<br>DATE |  |
| D 358  | Continued From pa   | ge 118  | D 358                     |  |                |                  |  |
|  | administered.   |   |                           |  |                |                  |  |
|  | revealed there was solution GaviLyte-G  | #8's July 2019 eMAR an entry for the bowel prep to be administered on with documentation it had   |                           |  |                |                  |  |
|  | Observation of Resident #8's medications available for administration 07/25/19 at 12:07pm revealed an unopened container of GaviLyte-G solution with a dispense date of 05/22/19.   |   |                           |  |                |                  |  |
|  | Telephone interview with a representative from the facility's contracted pharmacy on 07/25/19 at 10:37am revealed: -The facility faxed physician's orders to the pharmacyThe pharmacy entered the orders into the eMAR systemIf the order provided a start date, the pharmacy |   |                           |  |                |                  |  |
|  | that dateIf the order did not pharmacy would er eMAR for the follow-If the physician's o  | rder was new, the facility had<br>R system and approve it before  |                           |  |                |                  |  |
|  | -The pharmacy had<br>Resident #8's GoLy<br>-The pharmacy rec<br>#8's GoLytely on 05<br>one-time supply to<br>-The pharmacy ent<br>order onto the eMA<br>(05/23/19) because<br>-The facility had the   | I received only one order for rely. eived an order for Resident 5/22/19 and dispensed a the facility on the same day. ered Resident #8's GoLytely R for the following day it did not have a start date. e ability to adjust dates and administration, if necessary, |                           |  |                |                  |  |

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 358 Continued From page 119 D 358 to coordinate administration of the GoLytely with the scheduled colonoscopy. Interview with a second shift Medication Aide (MA) on 07/25/19 at 4:11pm revealed: -She worked 7:00am to 12:15am on 07/14/19 and was the only supervisor on staff that day. -She was very busy and did not remember Resident #8's GoLytely populating on the eMAR for administration. -She did not administer the GoLvtelv but documented she had administered it probably because she was so busy. Interview with the Resident Care Coordinator (RCC) on 07/25/19 at 2:33pm revealed: -She had been the RCC since 07/08/19. -The RCC was responsible for faxing new orders to the pharmacy and approving those orders in the eMAR system after they were entered by the pharmacy. -She had the capability of adjusting dates and times of administration in the eMAR system, if needed, so medications such as GoLytely could be administered based on the appointment date for the colonoscopy. -She did not work at the facility during Resident #8's 05/03/19 and 05/13/19 scheduled colonoscopy appointments. -Resident #8 missed her 07/15/19 colonoscopy appointment because she was not administered GoLytely on 07/14/19 and because she ate breakfast on 07/15/19. -She did not know why the MA did not administer GoLytely to Resident #8 on 07/14/19.

Division of Health Service Regulation

9:04am revealed:

Interview with the Administrator on 07/25/19 at

-She had worked at this facility for 3 weeks. -The RCC was responsible for sending orders to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | ' '  | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |       |                          |
|--|--|--|---------------------|--|-------|--------------------------|
|  |  | HAL060149  | B. WING             |  | 07/2  | 9/2019                   |
| NAME OF  | PROVIDER OR SUPPLIER   | 4815 NOR   |                     | STATE, ZIP CODE<br>N AMITY ROAD<br>105   |       |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULI.<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |
| D 358  | the pharmacy.  -The pharmacy enter computer profile.  -Once the medication facility, it was the Reand approve the orea the pharmacy.  -The RCC was responshed the emandary.  -The RCC was responshed the emandary.  -The RCC was responshed the emandary.  -The RCC was responshed to the emandary of the eman | ered orders into a resident's on was dispensed to the CC's responsibility to verify der entered onto the eMAR by consible for entering the date tely should be administered of the colonoscopy consible for assuring all moscopy preparation, administration, were followed ent #3's FL2 dated 07/03/19 included chronic kidney betes, and hypertension.  The ent #3 dated 07/03/19 or Gemfibrozil 600mg (a treat high cholesterol)  For Resident #3 dated an order for Gemfibrozil  False June 2019 electronic tration Record (eMAR)  For Gemfibrozil 600mg one 8:00am and 8:00pm.  For the entering the date and the entering electronic dentered in the electronic dentered in th | D 358               |  |       |                          |

Division of Health Service Regulation

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROV

|                          | IT OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | l ` ′               | E CONSTRUCTION   | (X3) DATE |                          |
|--------------------------|--|---|---------------------|--|-----------|--------------------------|
| AND FLAN                 | OF CORRECTION  | IDENTIFICATION NOMBER   | A. BUILDING:        |  | COMPLETED |                          |
|                          |  | HAL060149   | B. WING             |  | 07/2      | 29/2019                  |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |           | _                        |
| EAST TO                  | WNE  |   |                     | N AMITY ROAD   |           |                          |
|                          |  | ***************************************   | TTE, NC 282         |  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE      | (X5)<br>COMPLETE<br>DATE |
| D 358                    | Continued From pa  | ge 121  | D 358               |  |           |                          |
|                          | Review of Resident revealed: -There was an entry tablet twice daily at -There was docume was administered to 07/01/19-07/19/19 to 06/21/19, 06/22/19, There was docume was not administere 8:00pm, and at 8:00 06/22/19.  Observation of med administration on 0   | #3's July 2019 eMAR  y for Gemfibrozil 600mg one 8:00am and 8:00pm. entation Gemfibrozil 600mg wice daily from ewice daily and at 8:00am on   |                     |  |           |                          |
|                          | pharmacy on 07/24, -Resident #3 was "pmedications were dipharmacyThe pharmacy dispresident #3 upon the An order for Gemfi administered twice of 07/02/19 and 30 pill dispensed on 07/02There were no other Gemfibrozil 600mg. Interview with a repadministration (VA) 12:41pm revealed than order for Gemfibresults dated 06/26/ | ispensed from another bensed medications for ne facility's requested brozil 600mg to be daily was received on s (15-day supply), and was /19. er requests received to fill for Resident #3.  resentative with the veteran pharmacy on 07/29/19 at he pharmacy had not received rozil 600mg. |                     |  |           |                          |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE<br>A. BUILDING:  | E CONSTRUCTION            | (X3) DATE SURVEY<br>COMPLETED  |       |                          |
|--|--|--|---------------------------|--|-------|--------------------------|
|  |  | HAL06014 <del>9</del>  | B. WING                   |  | 07/2  | 9/2019                   |
| NAME OF I  | PROVIDER OR SUPPLIER   |  |                           | TATE, ZIP CODE   | •     | _                        |
| EAST TO  | OWNE   |  | RTH SHARON<br>FTE, NC 282 | I AMITY ROAD<br>05   |       |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE | (X5)<br>COMPLETE<br>DATE |
| D 358  | Continued From pa  | ge 122   | D 358                     |  |       |                          |
|  | -The reference rang<br>35-150mg/dL.  | ge listed for triglycerides was  |                           |  |       |                          |
|  | 12:50pm revealed: -He thought her recordered most of the He was not sure worderedAt times, there see normal.  Interview with a me 07/23/19 at 2:50pm -She normally work -Gemfibrozil was not for Resident #3She could not remout of Gemfibrozil. | hat medications he was emed to be less pills than dication aide (MA) on revealed: ed first shift as a MA. ot available for administration ember when Resident #3 ran |                           |  |       |                          |
|  | -She called the faci<br>get the medication<br>remember when sh<br>-She had not conta<br>pharmacy (VA) bec<br>medications to com  | and lead MA but she could not  |                           |  |       |                          |
|  | -She did not know with a sign of the MAs in Gemfibrozil was no -There was a lack cand the MAs.   | on 07/29/19 at 3:20pm:<br>what happened with Resident  |                           |  |       |                          |

|                          | ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | l ' '               | E CONSTRUCTION   | COMPLETED  |                          |
|--------------------------|---|--|---------------------|--|------------|--------------------------|
|                          |   | HAL060149  | B. WING             |  | 07/29/2019 |                          |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  | -          |                          |
|                          |   |  |                     | AMITY ROAD   |            |                          |
| EAST T                   | OWNE  |  | TTE, NC 282         | ········   |            |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |            | (X5)<br>COMPLETE<br>DATE |
| D 358                    | Continued From pa   | ge 123   | D 358               |  |            |                          |
|                          | (RCC) on 07/25/19 -She became the R -Medication orders and to the veteran's progress note should be a she with factor administrationShe spoke with factor administrationShe spoke with factor administrationShe spoke with factor and order to hold Gett was in the buildingThe MAs should held Gemfibrozil was not faxed the pharmacy "No one followed sure it was in the building "No one followed sure it was in the building "No one followed sure it was in the building "No one followed sure it was in the building "No one followed sure it was in the building "No one followed sure it was in the building "No one followed sure it was in the building "The did not know I not available for ad-MAs were expected the there were issues of from the pharmacy "If a medication after sponsible for followed There were supposed "She was not sure of Resident #3's medicationer (NP) or Interview with the factor of the practitioner (NP) or Interview with the factor of the practitioner (NP) or Interview with the factor of the practitioner (NP) or Interview with the factor of the practitioner (NP) or Interview with the factor of the practitioner (NP) or Interview with the factor of the practitioner (NP) or Interview with the factor of the practitioner (NP) or Interview with the factor of the practitioner (NP) or Interview with the factor of the practitioner (NP) or Interview with the factor of the practitioner (NP) or Interview with the factor of the practitioner (NP) or Interview with the factor of the practitioner (NP) or Interview with the factor of the practitioner (NP) or Interview with the factor of the practitioner (NP) or Interview with the practitioner (NP) or Interview with the practic of the pract | were supposed to be faxed administration (VA) and a ald be made. Gemfibrozil was not available cility's contracted licensed id 19 to notify and he provided emfibrozil for Resident #3 until g. ave notified her that the t available and should have y. up on the medication to make uilding".  Director of Resident Care at 2:55pm revealed: Resident #3's Gemfibrozil was ministration. Id to communicate with her issues regarding the residents. MAs to notify her or the RCC if getting a medication delivered at 2:4 hours, the MAs were owing up with the pharmacy, sed to be weekly audits of the sent sure if there were being if a cart audit included review |                     |  |            |                          |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING:  | E CONSTRUCTION      |   | (X3) DATE SURVEY<br>COMPLETED |                          |  |
|--|---|---|---------------------|---|-------------------------------|--------------------------|--|
|  |   | HAL060149   | B. WING             |   | 07/2                          | 07/29/2019               |  |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE   |                               |                          |  |
| EAST TO  | EAST TOWNE 4815 NO. CHARLO  |   |                     | N AMITY ROAD<br>205   |                               |                          |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | ULD BE                        | (X5)<br>COMPLETE<br>DATE |  |
| D 358  | level "If his [Resident #3 lowered, his blood suncontrolled"If Gemfibrozil was Resident #3 would blood sugars which status, confusion, a -He did not know if Gemfibrozil was not Interview with the reprimary care provid 07/25/19 at 10:25ar aware the resident the facility's contract Interview with the A 4:20pm revealed: -MAs were suppose immediately if mediadministrationMAs were to notify hours if the medical requesting it from the The RCC and DRC eMAR system even errorsCart audits were to RCC and MAsShe implemented of the systolic blood pure Review of an order for the s | 3] triglycerides are not sugars will remain not administered as ordered, continue to have elevated could result in altered mental nd hospitalization. he was told that the travailable for administration. egistered nurse (RN) for the er (PCP) for Resident #3 on an revealed the PCP was not was ordered Gemfibrozil by sted nurse practitioner. dministrator on 07/25/19 at ed to contact the pharmacy cations were not available for the RCC or DRC within 24 tion was not available after | D 358               |   |                               |                          |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ' '  | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED                                |  |            |  |
|---|---|--|---------------------|--|--|------------|--|
|   |   | HAL060149  | B. WING             |  | 07/2   | 07/29/2019 |  |
| NAME OF I   | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |  | -          |  |
| EAST TO   | WNE   |  | TH SHARON           | NAMITY ROAD<br>205   |  |            |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT!<br>(EACH CORRECTIVE ACTION SHOUL | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |            |  |
| D 358   | Continued From pa   | ge 125   | D 358               |  |  |            |  |
|   | Metoprolol Tartrate 50mg twice daily and begin<br>Metoprolol Tartrate 100mg one tablet twice daily.       |  |                     |  |  |            |  |
|   | Review of Resident #3's FL2 dated 07/03/19 revealed an order for metoprolol 100mg one tablet twice daily. |  |                     |  |  |            |  |
|   | Review of Resident #3's June 2019 electronic Medication Administration Record (eMAR) revealed:            |  |                     |  |  |            |  |
|   | -There was an entry for Metoprolol Tartrate<br>100mg one tablet twice daily at 8:00am and<br>8:00pm.      |  |                     |  |  |            |  |
|   |   | entation Metoprolol Tartrate<br>stered twice daily from                            |                     |  |  |            |  |
|   | 07/01/19-07/23/19   | #3's July 2019 eMAR from<br>revealed:<br>y for Metoprolol Tartrate                 |                     |  |  |            |  |
|   | 100mg one tablet to<br>8:00pm.  | vice daily at 8:00am and   |                     |  |  |            |  |
|   |   | entation Metoprolol Tartrate<br>stered twice daily from                            |                     |  |  |            |  |
|   | administration for R<br>2:50pm revealed:  | lications available for<br>tesident #3 on 07/23/19 at                              |                     |  |  |            |  |
|   | available for admini  | of Metoprolol Tartrate 50mg<br>stration.<br>remaining available for                |                     |  |  |            |  |
|   | administration.   |  |                     |  |  |            |  |
|   |   | resentative with Resident #3's<br>on 07/29/19 at 12:41pm                           |                     |  |  |            |  |
|   | -The pharmacy rece<br>50mg twice daily or   | eived an order for metoprolol<br>n 08/03/18.<br>d 180 metoprolol 50mg tablets      |                     |  |  |            |  |

| AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING:                                       |                     | (X3) DATE SURVEY<br>COMPLETED  |       |                          |
|--|--|---|---------------------|--|-------|--------------------------|
|  |  | 1181 000440   | B. WING             |  | 07/0  | 0/0040                   |
| NAME OF  | DOLUBER OF SUBBLIER  | HAL060149   |                     | TATE 710 0005  | 07/2  | 9/2019                   |
|  | PROVIDER OR SUPPLIER   |   |                     | STATE, ZIP CODE<br>N AMITY ROAD  |       |                          |
| EAST TO  | OWNE   |   | TE, NC 282          |  |       |                          |
| (X4) ID<br>PREFIX<br>TAG                         | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE | (X5)<br>COMPLETE<br>DATE |
| D 358  | Continued From pa  | ge 126  | D 358               |  |       |                          |
|  | on 02/18/19 and on 05/16/19The pharmacy had not received an order for metoprolol 100 twice daily that was written on 06/26/19.   |   |                     |  |       |                          |
|  | Telephone interview with the facility's contracted pharmacy on 07/24/19 at 9:04am revealed: -Resident #3 was "profile only" and his medications were primarily dispensed from another pharmacyThe pharmacy had never filled an order for Metoprolol TartrateThe pharmacy received an order for Metoprolol Tartrate 100mg to be administered twice daily, however the medication had not been dispensedMedications for Resident #3 were only dispensed if the facility called and made a request.  Interview with Resident #3 on 07/24/19 at 12:50pm revealed: -He thought he received his medications as ordered most of the timeHe was not sure what medications he was |   |                     |  |       |                          |
|  | 07/23/19 at 2:50pm -She normally work -She told the RCC I when she notified h -Resident #3 was p 100mg twice dailyShe administered t Resident #3.  | ed first shift as a MA.<br>out she could not remember                         |                     |  |       |                          |
|  |  | ead medication aide<br>on 07/29/19 at 3:20pm the<br>ng metoprolol 100mg twice |                     |  |       | _                        |

| AND BLAN OF CODECTION DENTIFICATION NUMBERS |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                         | (X3) DATE SURVEY<br>COMPLETED   |      |                          |
|---|--|---|-------------------------|---|------|--------------------------|
|   |  |   |                         |   |      |                          |
|   |  | HAL060149   | B. WING                 |   | 07/2 | 9/2019                   |
| NAME OF I                                   | PROVIDER OR SUPPLIER   |   |                         | STATE, ZIP CODE   |      |                          |
| EAST TO                                     | WNE  |   | TH SHARON<br>TE, NC 282 | NAMITY ROAD   |      |                          |
| (X4) ID<br>PREFIX<br>TAG                    | (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO | D BE | (X5)<br>COMPLETE<br>DATE |
|   |  |   |                         | DEFICIENCY)   |      |                          |
| D 358                                       | Continued From pa  | ge 127  | D 358                   |   |      |                          |
|   | daily twice daily, "I g  | guess it was not caught".   |                         |   |      |                          |
|   | (RCC) on 07/25/19 -She noticed the order metoprolol changed 100mg twice dailyShe thought Resid tablets on the cartResident #3 was "properties of the cart and the cart a | rirector of Resident Care at 2:55pm revealed: Metoprolol Tartrate 100mg pensed for Resident #3. MAs to administer two 50mg tablets and contact the graphets dispensed. If a cart audit included review                            |                         |   |      |                          |
|   | practitioner (NP) on<br>-He ordered Metopo<br>daily for Resident #<br>-If Resident #3 was<br>Tartrate as ordered   | acility's contracted nurse<br>07/24/19 at 1:05pm revealed:<br>rolol Tartrate 100mg twice<br>3 to treat high blood pressure.<br>not administered Metoprolol<br>, the residents' blood pressure<br>and but the resident at risk for |                         |   |      |                          |
|   | 4:20pm revealed sh   | dministrator on 07/25/19 at<br>ne expected MAs to administer<br>ered by the physician.  |                         |   |      |                          |
|   | revealed an order for  | ician's order dated 12/21/18<br>or Artificial Tears Polyvinyl<br>one drop in both eyes four   |                         |   |      |                          |

Division of Health Service Regulation

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 358 Continued From page 128 D 358 Review of signed physician order for Resident #3 dated 06/26/19 revealed an order for Artificial Tears Polyvinyl Alcohol 1.4% instill one drop in both eyes four times daily. Review of Resident #3's June 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Artificial Tears Polyvinyl Alcohol 1.4% instill one drop in both eyes four time daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation artificial tears was not administered 17 out of 120 opportunities from 06/01-06/30/19, the reasons were not printed. Review of Resident #3's July 2019 eMAR from 07/01/19-07/23/19 revealed: -There was an entry for Artificial Tears Polyvinyl Alcohol 1.4% instill one drop in both eyes four time daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation artificial tears was not administered 40 out of 90 opportunities from 07/01/19-07/23/19, the reasons were not printed. Observation of medications available for administration for Resident #3 on 07/23/19 at 2:50pm revealed there was a one 15mL bottle of Artificial Tears Polyvinyl Alcohol 1.4% available for administration. Interview with a representative with Resident #3's outside pharmacy on 07/29/19 at 12:41pm -The pharmacy received an order for artificial tears, one drop in each eye four times daily on 12/18/19.

Division of Health Service Regulation

-The pharmacy dispensed one 15mL bottle on

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ' '  | E CONSTRUCTION            |   | E SURVEY<br>PLETED |                          |
|---|---|--|---------------------------|---|--------------------|--------------------------|
|   |   | HAL060149  | B. WING                   |   | 07/                | 29/2019                  |
| NAME OF                                       | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S            | TATE, ZIP CODE  |                    |                          |
| EAST TO                                       | OWNE  |  | RTH SHARON<br>TTE, NC 282 | I AMITY ROAD<br>05  |                    |                          |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE           | (X5)<br>COMPLETE<br>DATE |
| D 358   | Continued From pa   |  | D 358                     |   |                    |                          |
|   | 12/19/18 and on 06<br>30-day supply.  | /21/19 and both were for a   |                           |   |                    |                          |
|   | pharmacy on 07/24 -Resident #3 was "I medications were p another pharmacyThe pharmacy had artificial tears for Re -Medications for Re if the facility called a Interview with Resid 12:50pm revealed: -He thought her red ordered most of the -He received eye di | rimarily dispensed from I never filled an order for esident #3. esident #3 were only dispensed and made a request. dent #3 on 07/24/19 at eeived his medications as a time. rops "sometimes". ops because one of the tear ere damaged. |                           |   |                    |                          |
|   | 07/23/19 at 2:50pm -She normally work -She administered documented when -She could not rem artificial tears were -The artificial tears  | ed first shift as a MA. Resident #3's eye drops and administered. ember the reason why the not documented in June 2019. were administered in July now why it did not reflect   |                           |   |                    |                          |
|   | (RCC) on 07/25/19 -She had not notice administrations of a -She had not notice dispensed twice by   | ed the artificial tears were only  |                           |   |                    |                          |

Division of Health Service Regulation

| NAME OF PROVIDER OR SUPPLIER  EAST TOWNE  STREET ADDRESS, CITY, STATE, ZIP CODE  4815 NORTH SHARON AMITY ROAD  CHARLOTTE, NC 28205  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 130  tears medication to administer to Resident #3, -She did not know Resident #3 missed doses of artificial tears in June and July 2019She did not know why documented administrations of artificial tears did not appear on the eMAR 07/02/19-07/10/19Resident #3 was profile only with the contracted pharmacy as he received his medications from the veteran's administration (VA) pharmacy.   | URVEY<br>ETED            |
|---|--------------------------|
| EAST TOWNE  4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 130  tears medication to administer to Resident #3She did not know Resident #3 missed doses of artificial tears in June and July 2019She did not know why documented administrations of artificial tears did not appear on the eMAR 07/02/19-07/10/19Resident #3 was profile only with the contracted pharmacy as he received his medications from   | /2019                    |
| (X4) ID PREFIX TAG    CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   D 358   Continued From page 130   Lears medication to administer to Resident #3. She did not know Resident #3 missed doses of artificial tears in June and July 2019. She did not know why documented administrations of artificial tears did not appear on the eMAR 07/02/19-07/10/19. Resident #3 was profile only with the contracted pharmacy as he received his medications from  |                          |
| PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 130  tears medication to administer to Resident #3She did not know Resident #3 missed doses of artificial tears in June and July 2019She did not know why documented administrations of artificial tears did not appear on the eMAR 07/02/19-07/10/19Resident #3 was profile only with the contracted pharmacy as he received his medications from   |                          |
| tears medication to administer to Resident #3She did not know Resident #3 missed doses of artificial tears in June and July 2019She did not know why documented administrations of artificial tears did not appear on the eMAR 07/02/19-07/10/19Resident #3 was profile only with the contracted pharmacy as he received his medications from   | (X5)<br>COMPLETE<br>DATE |
| Interview with the Director of Resident Care (DRC) on 07/24/19 at 2:55pm revealed: -She expected the MAs to administer medications as orderedShe expected the MAs to notify her or the RCC if medications were not administered after 3 missed doses.  Interview with the registered nurse (RN) for the primary care provider (PCP) for Resident #3 on 07/25/19 at 10:25am revealed: -Resident #3 was ordered artificial tears four times per day to treat dry eyes.  Interview with the Administrator on 07/25/19 at 4:20pm revealed she expected MAs to administer medications as ordered by the physician.  6. Review of Resident #13 FL2 dated 01/17/19 revealed diagnosis included insomnia.  Review of a psychotherapy follow-up note signed and dated by the mental health physician's assistant (PA) on 06/24/19 for Resident #13 revealed: -Current medications included Vistaril 50mg at bedtime"At last visit, patient was started on Vistaril 50mg for insomnia". |                          |

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING: \_ B. WING 07/29/2019 HAL060149 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 Continued From page 131 D 358 Review of psychotherapy follow-up note signed and dated by the mental health PA on 07/23/19 for Resident #13 revealed current medications included Vistaril 50mg for insomnia at bedtime. Review of Resident #13's June and July 2019 electronic Medication Administration Record (eMAR) revealed there was no entry for Vistaril 50mg at bedtime. Telephone interview with the facility's contracted pharmacy on 07/29/19 at 11:18am revealed the

Interview with the lead medication aide/former RCC on 07/29/19 at 3:55pm revealed:

Vistaril 50mg order was never received.

- -Prior to 07/08/19, she was the RCC and was responsible for receiving orders for the mental health PA.
- -She never seen the order for the Vistaril 50mg for Resident #13.
- -The mental health PA would often write therapy notes about a medication and the order was not left in the building.
- -When she was the RCC, she would retrieve the psychotherapy notes from email and place in the residents' record.
- -She did not remember reviewing the psychotherapy notes for Resident #13.

Interview with the Resident Care Coordinator (RCC) on 07/29/19 at 3:45pm revealed:

- -She became the RCC on 07/08/19.
- -She did not know where the original order for Vistaril 50mg was located.
- -She did not realize Resident #13 was ordered Vistaril 50mg.
- -She had not reviewed Resident #13's psychotherapy notes.
- -She placed a call to the psychotherapy provider

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

| E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED                                |
|---|--|
| B. WING   |  |
| STATE, ZIP CODE   | 07/29/2019   |
|   |  |
| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE COMPLETE  |
|   |  |
| ,   | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO |

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 133 from the mental health provider. -The Vistaril 50mg order for Resident #13 should have been caught and faxed to the pharmacy. 7. Review of Resident #4's FL2 dated 01/21/19 revealed diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), hypoxia, acute renal failure and diabetes. a. Review of Resident #4's physician order dated 05/22/19 revealed an order for Levemir U-100 insulin, (a medication used to control elevated blood sugar), 30 units to be administered at bedtime. Review of Resident #4's physician order dated 06/19/19 revealed an order for Levemir U-100 insulin, administer 24 units at bedtime. Review of Resident #4's May and June 2019 electronic Medication Administration Record (eMAR), from 05/22/19 through 06/18/19 revealed: -There was an entry for Levemir insulin 30 units to be administered daily at 8:00pm, from 05/22/19 through 06/18/19. -There was documentation Levemir insulin was administered 28 out of 28 opportunities from 05/22/19 through 06/18/19. Review of Resident #4's June and July 2019

Division of Health Service Regulation

through 07/24/19.

06/18/19 through 07/24/19.

eMAR, from 06/19/19 through 07/24/19 revealed: -There was an entry for Levemir insulin 24 units to be administered daily at 8:00pm from 06/18/19

-There was documentation Levemir insulin was administered 37 out of 37 opportunities from

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|--|---|--|-------------------------------|--------------------------|
|                          |  | HAL060149  | B. WING                                 |  | 07/2                          | 9/2019_                  |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET ADI   | ORESS, CITY, S                          | STATE, ZIP CODE  |                               |                          |
| EAST TO                  | WNE  |  | TH SHARON<br>TE, NC 282                 | NAMITY ROAD  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| D 358                    | Observation of medadministration on 0 there was no Lever the medication cart refrigerator.  Observation of medadministration on 0 -There was a 10ml on the medication of the Levemir vial hattached to the vial bedtime."  -The vial was in an date handwritten as -The insulin was pioneck of the vial.  Interview with the final (MA) on 07/24/19 and she had been audicarts with the other she did not remen Resident #4's medicated with the medications inhalers, she would and record on the Fashe submitted the Coordinator (RCC) -She did not remen insulin vial for Resident she had administed insulin twice in the insulin twic | dications available for 7/23/19 at 2:55pm revealed nir insulin vial or flexpen on or in the medication  dications available for 7/24/19 at 9:10am revealed: vial of Levemir insulin U-100 eart. ad a computer generated label which read "Inject 30 units at medication bottle with the open co7/08/19. Etured with the contents to the rest shift Lead Medication Aide to 10:15am revealed: iting the medications on the Lead MA. The rif she had audited cations in the past month. The actions in the past month. The actions in the past month. The actions in the past month in the cart audit, she would be consummary (POS) and it is its were on the cart, were tablets or hand held check the quantity remaining POS. POS to the Resident Care or the Administrator. The received the consumer of the Levemir of the consumer of the Levemir. | D 358                                   |  |                               |                          |

| AND DIAN OF CODDECTION INDICATION MIMORD. |   |   | E CONSTRUCTION      | (X3) DATE<br>COMP  | SURVEY<br>LETED |                          |
|---|---|---|---------------------|--|-----------------|--------------------------|
|   |   | HAL060149   | B. WING             |  | 07/2            | 9/2019                   |
|   |   |   |                     | STATE, ZIP CODE<br>N AMITY ROAD  |                 |                          |
| (X4) ID<br>PREFIX<br>TAG                  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) | JLD BE          | (X5)<br>COMPLETE<br>DATE |
| D 358                                     | -She did not know vunused"She thought the M. #4's Novolog flexpet Levemir vial, since were sent as flexpet Interview with the Pon 07/24/19 at 12:4-Resident #4 was beginned blood sugars weekl rangesThe PCP requested blood sugars weekl rangesIf Resident #4's blowould become diso hospitalizedThe PCP states Rewere controlled on regimentHe did not know Rereceiving the night to was ordered at 24 under the expected his madministered.  Interview with the D. (DRC) on 07/24/19 -The MAs were expensed his madministered.  Interview with the D. (DRC) on 07/24/19 -The MAs were expensed his madministered.  Interview with the D. (DRC) on 07/24/19 -The MAs were expensed his madministered.  She was not sure if of the medications in the medications in the medication in the medicat | why the insulin vial "looked  As may have used Resident en in error instead of the all of the insulin medications ens.  Trimary Care Physician (PCP)  5pm revealed: eing monitored for his  d a print out of Resident #4's y to evaluate the blood sugar end of sugar was too high he riented and end up  esident #4's blood sugars his current medication  esident #4 had not been time dose of Levemir which units.  Trimary Care Physician (PCP)  5pm revealed: eing monitored for his  d a print out of Resident #4's y to evaluate the blood sugar was too high he riented and end up  esident #4 had not been time dose of Levemir which units.  The dication orders to be  pricector of Resident Care at 2:55pm revealed: Exected to communicate with any issues regarding the sent to be weekly audits of the sent sure if they were being if a cart audit included a review as to the quantity.  CC was monitoring the eMARs is not sure if they were she ended to the quantity.  CC was monitoring the eMARs is not sure if they were she emakes to the quantity. | D 358               |  |                 |                          |

Division of Health Service Regulation

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) D 358 Continued From page 136 D 358 -She did not know Resident #4 had a Levemir insulin vial sent from the pharmacy on 05/27/19 that was almost completely full. -No one had brought this to her attention. -She did not know why the Levemir insulin vial was almost full when the medication had been documented as administered 58 times since it had been dispensed. Telephone interview with the facility's contracted pharmacy on 07/24/19 at 3:30pm revealed: -Resident #4 had an order dated 05/22/19 for Levemir 30 units to be administered in the evening. -A 10ml vial of Levemir, administer 30 units in the evening, was sent to the facility on 05/27/19. -Resident #4 had an order dated 06/19/19 for Levemir 24 units to be administered in the evening, and was the most current order. -No additional vials or flexpens of Levemir have been requested by the facility or dispensed from the pharmacy. -The 10ml vial of Levemir insulin sent on 05/27/19 at 24 units daily would have lasted 41 days (until 07/07/19). -Since Resident #4 was administered 30 units for 28 days, the insulin would have been depleted sooner than 41 days. -Insulin is only sent to the facility with a physician's order and at the staff's request. -The fill history was as follows: -One vial was sent to the facility on 03/04/19, 04/11/19 and 05/27/19.

Division of Health Service Regulation

insulin injections.

Telephone interview with the second shift MA on

-She administered the Levemir insulin from the

-Resident #4 has a vial of Levemir insulin.
-Resident #4 never refused his medications or

07/25/19 at 10:30am revealed:

| AND BLAN OF CORRECTION TO IDENTIFICATION NUMBERS |   | 1 , ,  | E CONSTRUCTION            |   | SURVEY<br>PLETED |                          |
|--|---|--|---------------------------|---|------------------|--------------------------|
|  |   | HAL060149  | B. WING                   |   | 07/              | 29/2019_                 |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S            | STATE, ZIP CODE   |                  |                          |
| EAST TO  | OWNE  |  | RTH SHARON<br>FTE, NC 282 | I AMITY ROAD<br>05  |                  |                          |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD BE        | (X5)<br>COMPLETE<br>DATE |
| D 358  | Continued From pa   | ge 137   | D 358                     |   |                  |                          |
|  | -She did not know we fullShe always adminit Levemirinsulin from the control of | xpen for his Levemir insulin. why the insulin vial was almost istered Resident #4's if the vial. of any other Levemir insulin for if #4's A1C laboratory results   |                           |   |                  |                          |
|  | 4:20pm revealed: -The RCC and DRC eMAR system every errorsCart audits were to RCC and MAsShe implemented could be she did not know fivial had not been us 05/27/19 for admining the she will be     | with Resident #4 on 07/24/19   |                           |   |                  |                          |
|  | 05/11/19 revealed a U-100 insulin (a me elevated blood suga with meals.  Review of Residen 06/19/19 revealed a  | ent #4's physician order on an order for a Novolog flexpen edication used to control ar), 8 units three times a day at #4's physician order on an order for a Novolog flexpen its three times a day with |                           |   |                  |                          |

| AND PLAN OF CORRECTION DENTIFICATION NUMBER |  |  |                     |  | (3) DATE SURVEY<br>COMPLETED |                          |
|---|--|--|---------------------|--|------------------------------|--------------------------|
|   |  | HAL060149  | B. WING             | ,  | 07/2                         | 9/2019                   |
| NAME OF                                     | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |                              |                          |
| EAST TO                                     | NA/NIE   | 4815 NOR   | TH SHARON           | NAMITY ROAD  |                              |                          |
| EAST TO                                     | VVINE  | CHARLO   | TE, NC 282          | 05   |                              |                          |
| (X4) ID<br>PREFIX<br>TAG                    | IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE                         | (X5)<br>COMPLETE<br>DATE |
| D 358                                       | Continued From pa  | ge 138   | D 358               |  |                              |                          |
|   | Review of Resident medication adminis 06/19/19 through 06-There was an entry three times a day wat 7:00am, 12:00pm-There was docume units was administed and 5:00pm from 06-There was an entry units to be administed meals at 6:30am, 1'-There was docume administered three 11:30am and 4:30pm 06/25/19.  -On 06/20/19, 06/20/06/25/19 at 6:30am documented the administration of th | #4's June 2019 electronic tration record (eMAR) from 6/25/19 revealed: y for Novolog flexpen 8 units with meals, to be administered in and 5:00pm. entation Novolog flexpen 8 ered daily at 7:00am, 12:00pm 6/19/19 through 06/25/19. y for a Novolog flexpen 10 ered three times a day with 1:30am and 4:30pm. entation Novolog 10 units was a times a day at 6:30am, im from 06/19/19 through 1/19, 06/22/19, 06/24/19 and the third shift MA ministration of 10 units of Resident #4. 1/19, 06/22/19, 06/24/19 and the first shift MA documented of 8 units of Novolog insulin to 6/24/19, at 4:30pm, the cumented the administration og insulin to Resident #4. 6/24/19 at 5:00pm, another cumented the administration g insulin to Resident #4. |                     |  |                              |                          |
|   | administration.  | there were 2 entries on the  |                     |  |                              |                          |

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|   |  | A. BUILDING.  |  |   | _ETED  |
|---|--|---|--|---|--|
|   |  |   |  |   |  |
| HAL060149   |  | B. WING   |  | 07/2  | 9/2019   |
| ROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S  | STATE, ZIP CODE  |   |  |
| WNE   |  |   |  |   |  |
| (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU  | LD BE   | (X5)<br>COMPLETE<br>DATE   |
| Continued From pa   | ge 139   | D 358   |  |   |  |
| <ul> <li>Continued From page 139</li> <li>eMAR and 2 different dosages for administration for novolog insulin.</li> <li>-She administered the 7:00am dose of 8 units of Novolog insulin to Resident #4.</li> </ul>  |  |   |  |   |  |
| pharmacy on 07/24.  Orders received by physician were entered from the physician.  The pharmacy committerface with the farener from their search an order from their search was entered the pharmacy staff.  The default time for indicated by the physician of the physician of the physician of the pharmacy staff. | the pharmacy from a gred on the eMAR. discontinued, the pharmacy to have a discontinue order or Novolog flexpen 10 order on the eMAR on 06/19/19 by a orders not specifically orders not specifically orders of the facility staff to  |   |  |   |  |
| Interview with the R revealed: -She did not review -She thought the RC accuracyThe RCC and the I facility in July of 20° -She did not know v Novolog insulin to b Interview with the R revealed: -She reviewed new  | CD on 07/25/19 at 3:20pm the eMARs for accuracy. CC reviewed the eMARs for RCD were employed at the 19. who entered the times for the e administered. CC on 07/25/19 at 4:10pm orders on the eMAR before   |   |  |   |  |
|   | SUMMARY STAY (EACH DEFICIENCY REGULATORY OR LS)  Continued From pare eMAR and 2 differe for novolog insulinShe administered to Novolog insulin to Form the pharmacy on 07/24, -Orders received by physician were entered from the physicianThe pharmacy cominterface with the farent from the physician interface with the farent from the physician's order from their staff was entered the pharmacy staffThe default time for indicated by the physicianed by the physicianed was the responsive adjust the times as interview with the Revealed:  -She did not review -She thought the RC and the facility in July of 20° -She did not know with the Revealed: -She reviewed new approving the entry | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 139  eMAR and 2 different dosages for administration for novolog insulin.  -She administered the 7:00am dose of 8 units of Novolog insulin to Resident #4.  Telephone interview with the facility's contracted pharmacy on 07/24/19 at 3:30pm revealed:  -Orders received by the pharmacy from a physician were entered on the eMAR.  -For an order to be discontinued, the pharmacy staff were required to have a discontinue order from the physician.  -The pharmacy computer system does not interface with the facility software.  -The facility management staff could discontinue an order from their site.  -The physician's order for Novolog flexpen 10 units to be administered three times a day before meals was entered on the eMAR on 06/19/19 by the pharmacy staff.  -The default time for orders not specifically indicated by the physician was 1:00am.  -It was the responsibility of the facility staff to adjust the times as needed for administration.  Interview with the RCD on 07/25/19 at 3:20pm revealed:  -She did not review the eMARs for accuracy.  -She thought the RCD were employed at the facility in July of 2019.  -She did not know who entered the times for the Novolog insulin to be administered.  Interview with the RCC on 07/25/19 at 4:10pm | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 139  eMAR and 2 different dosages for administration for novolog insulin.  She administered the 7:00am dose of 8 units of Novolog insulin to Resident #4.  Telephone interview with the facility's contracted pharmacy on 07/24/19 at 3:30pm revealed:  -Orders received by the pharmacy from a physician were entered on the eMAR.  -For an order to be discontinued, the pharmacy staff were required to have a discontinue order from the physician.  -The pharmacy computer system does not interface with the facility software.  -The physician's order for Novolog flexpen 10 units to be administered three times a day before meals was entered on the eMAR on 06/19/19 by the pharmacy staff.  -The default time for orders not specifically indicated by the physician was 1:00am.  -It was the responsibility of the facility staff to adjust the times as needed for administration.  Interview with the RCD on 07/25/19 at 3:20pm revealed:  -She did not review the eMARs for accuracy.  -She thought the RCD were employed at the facility in July of 2019.  -She did not know who entered the times for the Novolog insulin to be administered.  Interview with the RCC on 07/25/19 at 4:10pm revealed:  -She reviewed new orders on the eMAR before approving the entry. | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 139  eMAR and 2 different dosages for administration for novolog insulin.  She administered the 7:00am dose of 8 units of Novolog insulin to Resident #4.  Telephone interview with the facility's contracted pharmacy on 07/24/19 at 3:30pm revealed:  -Orders received by the pharmacy from a physician were entered on the eMAR.  -For an order to be discontinued, the pharmacy staff were required to have a discontinue an order from their site.  -The pharmacy computer system does not interface with the facility software.  -The facility management staff could discontinue an order from their site.  -The physician's order for Novolog flexpen 10 units to be administered three times a day before meals was entered on the eMAR on 06/19/19 by the pharmacy staff.  -The default time for orders not specifically indicated by the physician was 1:00am.  -It was the responsibility of the facility staff to adjust the times as needed for administration.  Interview with the RCD on 07/25/19 at 3:20pm revealed:  -She did not know who entered the times for the Novolog insulin to be administered.  Interview with the RCC on 07/25/19 at 4:10pm revealed:  -She cid not know who entered the times for the Novolog insulin to be administered. | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  (EACH CORRECTION SHOULD BE CROSS-REFERINCED  (EACH CORRECTION SH |

| AND DIAM OF CORRECTION 1 DENTIFICATION NUMBER: |   | ' '   | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |        |                          |
|--|---|---|---------------------|--|--------|--------------------------|
| HAL060149                                      |   | B. WING   |                     | 07/2   | 9/2019 |                          |
| NAME OF  | PROVIDER OR SUPPLIER  | 4815 NOR  |                     | STATE, ZIP CODE<br>N AMITY ROAD<br>105   |        |                          |
| (X4) ID<br>PREFIX<br>TAG                       | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE  | (X5)<br>COMPLETE<br>DATE |
| D 358  | existing ordersShe had been imp MAs to audit their or- She also had been herselfShe verified the resummary with the recartShe did not know to documented as adrunits on the eMAR.  c. Review of Resided dated 06/06/19 revealed dated 06/06/19 revealed puff every day.  Review of Resident electronic Medication (eMAR) from 06/06 revealed: -There was an entry be administered daily a through 07/23/19There was docume administered daily a through 07/23/19Incruse Ellipta was 48 times from 06/06 Observation of mediadministration on 00 -There was an Incruinside a plastic bag pharmacy labelThe dispense date and the handwritter | lementing and training the  | D 358               |  |        |                          |

Division of Health Service Regulation

| AND DUAN OF CODDECTION DENTIFICATION NUMBER: |   |  |                     |  | SURVEY<br>LETED |                          |
|--|---|--|---------------------|--|-----------------|--------------------------|
|  |   | HAL060149  | B. WING             |  | 07/2            | 9/2019                   |
| NAME OF                                      | PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, S      | STATE, ZIP CODE  |                 |                          |
| EAST TO                                      | OWNE  |  | TH SHARON           | NAMITY ROAD<br>205   |                 |                          |
| (X4) ID<br>PREFIX<br>TAG                     | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE           | (X5)<br>COMPLETE<br>DATE |
| D 358  | counter, indicating administered, and administered, and administered since.  Interview with the P on 07/24/19 at 12:4-Resident #4 had condition and chronic obstruction of breath.  He was on two school (PRN) hand held in nebulizer treatment due to his diagnose. It was important for his scheduled breat treatments.  He did not know R receiving the Incruse-Resident #4 had not breathing difficulties.  Observation on 07/2 to the hospital with exacerbation of CO.  Telephone interview pharmacy on on 07-Resident #4 had and for Incruse Ellipta 6 mouth daily.  The pharmacy disposition on the medication had one Incruse Ellipta 6 mouth daily. | is displayed on the dose 12 doses were left to be 18 doses had been 06/06/19.  rimary Care Physician (PCP) 5pm revealed: ongestive heart failure (CHF) stive pulmonary disease Ity in breathing and shortness reduled and one as needed halers, and on a PRN for shortness of breath (SOB) is. In his health that he received ching treatments and his PRN resident #4 had not been a Ellipta as ordered. It complained to him of any is.  24/19, Resident #4 was sent a diagnosis of dyspnea and PD.  With the facility's contracted /24/19 at 3:30pm revealed: In active order dated 06/06/19 2.5mcg, inhale 1 puff by  Deensed inhalers for residents order and at the facility's medication was completed or | D 358               |  |                 |                          |

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 358 Continued From page 142 D 358 on 06/06/19. -No further requests from the facility for Incruse Ellipta were received or dispensed from the pharmacy. -The starting dose was identified as "30" in the dose counter window. -Each administration will bring this number down -If Resident #4 was receiving daily doses of the Incruse Ellipta, he should have completed the medication on 07/07/19. Interview with a Medication Aide (MA) on 07/25/19 at 10:40am revealed: -She administered the Incrusa Ellipta breathing treatment to Resident #4 when she worked on this medication cart. -She did not put the open date on the plastic bag that the device was in. -She did not know how long the medication should last-she thought 30 or 45 days. -She did not usually assist with cart audits. -When she did assist with cart audits, she made sure the medication was on the cart but did not check to see how many doses were left with the inhalers Interview with the Director of Resident Care (DRC) on 07/25/19 at 3:20pm revealed: -She had been reviewing the resident's records for compliance. -The RCC had been overseeing the medications,

Division of Health Service Regulation

practitioner.

the medication carts and the orders.

medication carts in this facility.

-She did not know the process used to audit the

-She expected the MAs to report to her or the RCC if there was a problem with medications. -She expected the MAs to administer the medications as ordered by the licensed

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A. BUILDING:        |  | (X3) DATE SURVEY<br>COMPLETED                     |   |
|--|---|---|---------------------|--|---|---|
| HAL060149  |   | B. WING   |                     | 07/29/2019   |   |   |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE |   |   |                     |  |   |   |
| EAST TOWNE 4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205        |   |   |                     |  |   |   |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | CTIVE ACTION SHOULD BE<br>ICED TO THE APPROPRIATE |   |
| D 358  | Continued From page 143   |   | D 358               |  |   | · |
|  | -She did not know the daily scheduled Incruse Ellipta had 18 doses administered in 48 days.   |   |                     |  |   |   |
|  | Interview with the A 4:20pm revealed: -The RCD and the clinical aspects of the second and requested carts to be completed carts to be completed carthe RCC and herseThe completed carthe RCC and herseShe had not review dateShe did not know the doses administered as ordered by the publication of the publication of the publication of the second and the second | dministrator on 07/25/19 at  RCC were responsible for the he facility. If audits of the medication ed as soon as possible last at order forms were given to lift. If wed the current cart audits to the Incruse Ellipta had 18 in 48 days.  MAs to administer medications only sician.  Resident Care Coordinator at 12:15pm revealed: sitioning the cart audits to the should be.  As on the process and |                     |  |   |   |
|  | day on their medical physician's order sumedications for that -The MAs returned the RCC and she re  | e assigned 4-5 residents each<br>ation cart and verify the<br>ummary (POS) with the   |                     |  |   |   |
|  | -The MAs should b<br>inhalers, eye drops<br>medication that doe<br>the pharmacy- for c<br>-She did not know to<br>doses administered  | e checking the handheld<br>, creams, insulin-any<br>es not come on cycle fill from<br>dates opened and refills.<br>the Incruse Ellipta had 18<br>d in 48 days.<br>g daily cart audits until all the   |                     |  |   |   |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|---|---|--|-------------------------------|--------------------------|
|                          |  |   | , a bolebillo.                          |  |                               |                          |
|                          |  | HAL060149   | B. WING                                 |  | 07/2                          | 9/2019                   |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |   | STATE, ZIP CODE  |                               |                          |
| EAST TO                  | FAST TOWNE   |   | TH SHARON<br>TE, NC 282                 | NAMITY ROAD<br>105   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| D 358                    | Continued From pa  | ge 144  | D 358                                   |  |                               |                          |
|                          | resident's medication  | ons on the carts had been   |   |  |                               |                          |
|                          | Interview with the le 07/29/19 at 3:20pm - She had assisted i for the past few mo - The process in aud to print the POS and on the POS were or - She usually audite at a time.  - The POS sheet was RCD for their review - If the medications order them through - She had audited R but could not rememedications.  - The MAs should a medications and elimated and in the medications and elimated in the medication in th | n auditing the medication carts on ths. diting the medication cart was determine if the medications in the cart. d 4 or 5 resident's medications as given to the Administrator or w. were not on the cart she would the pharmacy. esident #4's medication cart, in the rif she audited his lso be reviewing the MARS every day and reporting hey find. It caught".  ent #4's physician order dated an order for Spiriva handihaler, a device daily.  #4's May and June 2019 on Administration Record /19 through 06/05/19  y for Spiriva handihaler, inhale e once daily, to be |   |  |                               |                          |

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: \_\_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 358 D 358 Continued From page 145 Telephone interview with the facility's contracted pharmacy on on 07/24/19 at 3:30pm revealed there was no record of the pharmacy dispensing Spiriva handihaler to the facility for Resident #4. Observation of medications available for administration on 07/23/19 at 2:55pm revealed there was no Spiriva handihaler on the medication cart. Interview with the MA on 07/23/19 at 3:05pm revealed she did not recall administering Spiriva to Resident #4. Interview with the lead MA/former Resident Care Coordinator on 07/29/19 at 3:30pm revealed: -Resident #4 had gone out to the hospital several times. -The Spiriva may have been a discharge order and his insurance would not cover it. -She did not remember the order. The facility failed to assure medications were administered as ordered for several residents. including Resident #4 who had a diagnosis of chronic obstructive pulmonary disorder (COPD) and missed 30 of 48 doses of Incruse Ellipta and 8 of 8 doses of Spiriva, resulting in a hospitalization for shortness of breath. The failure of the facility to assure medications were administered resulted in physical harm to Resident #4 and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 07/24/19. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 26.

|               | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED   |   |
|---------------|--|---|--|--|---|---|
|               |  | HAL060149   | B. WING                                  |  | 07/29/2019  |   |
| NAME OF F     | SUMMARY STA  | STREET ADD<br>4815 NOR<br>CHARLOT<br>TEMENT OF DEFICIENCIES   | TH SHARON<br>TE, NC 282                  | PROVIDER'S PLAN OF CORRECTI  | ON  | (X5)<br>COMPLETE  |
| PRÉFIX<br>TAG |  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG                            | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  |   | DATE  |
| D 367         | (j) The resident's n record (MAR) shall following: (1) resident's name (2) name of the me (3) strength and do administered; (4) instructions for or treatment; (5) reason or justifi medications or treadocumenting the redications or treadocumentation medications or treadocumentation medications or treadomission, including (8) name or initials the medication or the signature equivalent. | 04 Medication Administration nedication administration be accurate and include the strategy of the person administering the medication administering the medication administering the medication cation for the administration of atments as needed (PRN) and esulting effect on the resident; of administration; of any omission of atments and the reason for the prefusals; and, of the person administering reatment. If initials are used, a not to those initials is to be maintained with the medication | D 367                                    | 10A NCAC 13F .1004(j) Medication Administration  Facility will ensure the resident's madministration record (MAR) is accompleted full audit of EMARs and Physicians Orders. Senior VP of Clinical Services intiate experience Resident Care Directors completed an on-site audit of all end and Physicians Orders  Facility ED, RCC, DRC and/or Dewill review/audit eMARs for accurates than monthly for one month, transdonly there after.  Facility Medication Aides have be trainined on proper documentation.  Facility Medication Aides have retrained on Medication Administration provided by a Licensed RN and Facility Medication Administration. | edication<br>urate<br>ed a team<br>s which<br>IARs<br>signee<br>acy no<br>hen<br>en | 8/26/19<br>8/21/19<br>8/23/19<br>7/25/19,<br>8/15/19 &<br>8/22/19 |
|               | Based on observatinterviews, the faci accuracy of the ele Administration Rec sampled residents parameters for the  | net as evidenced by: tions, record reviews, and lity failed to assure the ectronic Medication cords (eMARs) for 4 of 10 related to documenting administration of an insulin etes and a medication used to   |  |  |   |   |

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING HAL060149 07/29/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 367 D 367 Continued From page 147 treat high blood pressure (Resident #3), a medication used to prepare for a colonoscopy procedure (Resident #1 and #8), and documenting the administration of a hand held inhaler under the incorrect eMAR entry (Resident #4). The findings are: 1. Review of Resident #3's current FL-2 dated 07/03/19 revealed diagnoses included chronic kidney disease, type 2 diabetes, peripheral neuropathy, history of cerebral vascular disease with left sided weakness, and hypertension. a. Review of Resident #3's physician's orders dated 12/28/18 revealed: -There was an order to administer Novolog insulin 100 units/mL inject 2 to 10 units (sliding scale) before meals and at bedtime for diabetes. -The sliding scale was as follows: 150-200; 2 units, 201-250; 4 units, 251-300; 6 units, 301-350; 8 units, 351-400; 10 units, if greater than 401 go to the emergency room or urgent care. Review of Resident #3's May 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Novolog insulin 100unit/mL, check fingerstick blood sugar (FSBS) and inject per sliding scale for 6:30am. -The entry for 6:30am included the initials of the

Division of Health Service Regulation

result.

insulin administered.

medication aide that administered the medication. -There was no space to document the FSBS

-There was no space to document the units of

-There was no entry for the Novolog order to be implemented before lunch, dinner, or bedtime. -It could not be determined how many units of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | 1 ' '  | E CONSTRUCTION      |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|--|--|---------------------|---|-------------------------------|--------------------------|
|  |  | HAL060149  | B. WING             |   | 07/2                          | 9/2019                   |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S      | STATE, ZIP CODE   |                               | •                        |
| EAST TO  | EAST TOWNE 4815 NO CHARLO  |  |                     | NAMITY ROAD<br>05   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>GROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE                        | (X5)<br>COMPLETE<br>DATE |
| D 367  | sliding scale from 0 Review of Resident revealed: -There was an entry 100unit/mL, check is and inject per slidinThe entry for 6:30a medication aide that the entry implemented before the entry implemented before entry implemented before entry in was administable sliding scale from 0 Review of the facility medication regimer completed on 06/25 instruction for nursi NovoLog sliding scale instruction for nursi NovoLog sliding scale in entry in was entered at 6:30am, plassale is evaluated from at 6:30am, plassale is evaluated from all and at bedtim linterview with a lea 07/24/19 at 3:53pmWhen Resident #3 insulin, there was mecord the blood sure administeredShe notified the Resident entry in the entry | tered to the resident per the 5/01/19-05/31/19 at 6:30am.  #3's June 2019 eMAR  y for Novolog insulin fingerstick blood sugar (FSBS) g scale for 6:30am.  am included the initials of the at administered the medication. See to document the FSBS to the end to the Novolog order to be a lunch, dinner, or bedtime. For the Novolog order to be a lunch, dinner, or bedtime. For the 16/01/19-06/26/19 at 6:30am.  By's contracted pharmacist's in review consultation for the end of t | D 367               |   |                               |                          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING:  | E CONSTRUCTION           | (X3) DATE SURVEY<br>COMPLETED  |       |                          |
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|  |   |   |                          |  |       |                          |
|  |   | HAL060149   | B. WING                  |  | 07/2  | 9/2019                   |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S           | STATE, ZIP CODE  |       |                          |
| EAST TO  | OWNE  |   | TH SHARON<br>TTE, NC 282 | NAMITY ROAD  |       |                          |
| 0/ 0 10  | CHRANACOV OTA   |   |                          |  |       |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE | (X5)<br>COMPLETE<br>DATE |
| D 367  | Continued From pa   | ge 149  | D 367                    |  |       |                          |
|  | RCC and DRC.  | ember when she notified the   |                          |  |       |                          |
|  | (RCC) on 07/24/19 -The fingerstick blo- Resident #3 was or parameters were no was enteredThe parameters we  | tesident Care Coordinator at 10:05am revealed: od sugar (FSBS) order for the eMAR, however the ot checked when the order ere not checked in the eMAR e orders did not appear on the                   |                          |  |       |                          |
|  | Resident Care Coo<br>10:48am revealed:<br>-She was the RCC<br>-She approved the<br>the eMAR system for<br>-She did not realize<br>Novolog were not country<br>-The corporate nurse<br>into the eMAR system<br>training on the eMA<br>-She did not know to<br>scale insulin were re- | Novolog sliding scale order in or Resident #3. the sliding scale units for the hecked in the eMAR system. se gave her orders to enterem, she did not have any R system. he parameters for the sliding |                          |  |       |                          |
|  | 4:20pm revealed: -The lead MA was to she did not receive step downThe RCC and the limplementing parare eMARThe eMARs were to  | dministrator on 07/25/19 at he previous RCC, however training and was asked to DRC were responsible for neters populated on the to be checked daily by the DRC and changes were to be                 |                          |  |       |                          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION           | (X3) DATE SURVEY<br>COMPLETED  |       |                          |
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|  |  |  | D MAINO                  |  |       |                          |
|  |  | HAL060149  | B, WING                  |  | 07/2  | 9/2019                   |
| NAME OF  | PROVIDER OR SUPPLIER   |  |                          | STATE, ZIP CODE  |       |                          |
| EAST TO  | OWNE   |  | TH SHARON<br>TTE, NC 282 | NAMITY ROAD<br>05  |       |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |
| D 367  | Continued From pa  | ge 150   | D 367                    |  |       |                          |
|  | made as needed.  |  |                          |  |       |                          |
|  | 06/26/19 revealed: -There was an order to treat high blood p   | ed physician's order dated<br>or for metoprolol tartrate (used<br>pressure) 50mg twice daily,<br>od pressure less than 125, the<br>6/18. |                          |  |       |                          |
|  | Medication Administrevealed: -There was an entry twice daily hold for than 125The metoprolol tary administered from the company of the commented on the reverse and the commented on the revealed.       | ce for blood pressures to be eMAR.<br>eMAR.<br>umentation that the resident's  |                          |  |       |                          |
|  | revealed: -There was an entrictivice daily hold for than 125The metoprolol tar administered from There was no space documented on the There was no documented on the 100 pressure was 06/01/19-06/21/19. | ce for blood pressures to be eMAR.  umentation that the resident's   |                          |  |       |                          |
|  | revealed:  | cumented blood pressures   |                          |  |       |                          |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |      |                          |
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|   |  |  | B. WING             |  |      | 0/0040                   |
| NAME OF   | PROVIDER OR SUPPLIER   | HAL060149  |                     | STATE, ZIP CODE  | 07/2 | 9/2019                   |
|   |  |  |                     | I AMITY ROAD   |      |                          |
| EAST TO   | _  |  | TE, NC 282          |  |      |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE |
| D 367   | Continued From page 151  |  | D 367               |  |      |                          |
|   | -There were 4 blood pressures documented from 06/20/19-06/21/19.   |  |                     |  |      |                          |
|   | Interview with a lead medication aide (MA) on 07/24/19 at 3:53pm revealed: -She did not know why Resident #3's blood   |  |                     |  |      |                          |
|   | pressures were not listed on the eMAR, but "we always check his blood pressure"No one ever told her to document the blood  |  |                     |  |      |                          |
| pressures anywhere else.  |  |  |                     |  |      |                          |
|   | Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 10:05am revealed:  -The parameters were not checked in the eMAR system therefore the orders did not appear on the eMAR.  -She noticed that the parameters were not |  |                     |  |      |                          |
|   |  | eMAR and corrected it. ead medication aide/previous  |                     |  |      | •                        |
|   | 10:48am revealed:  | rdinator (RCC) on 07/24/19 at  |                     |  |      |                          |
|   | parameters were no<br>-The corporate nursinto the eMAR system<br>training on the eMA<br>-She did not know to<br>pressure paramete  | the blood pressure of implemented on the eMAR. se gave her orders to enter em, and she did not have any AR system. the parameters for the blood rs were not entered. |                     |  |      |                          |
|   | 4:20pm revealed: -The lead MA was she did not receive step downThe RCC and the   | the previous RCC, however training and was asked to  DRC were responsible for meters populated on the  |                     |  |      |                          |
|   | eMAR.  | •  |                     |  |      |                          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLI<br>A. BUILDING:  | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |            |                          |
|---|---|--|---------------------|--|------------|--------------------------|
|   |   | HAL060149  | B. WING             |  | 07/29/2019 |                          |
|   |   |  |                     | TITE TIP AGE   | 1 0112     | 9/2019                   |
| NAME OF   | PROVIDER OR SUPPLIER  |  |                     | ITATE, ZIP CODE<br>NAMITY ROAD   |            |                          |
| EAST TO   | OWNE  |  | TE, NC 282          |  |            |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE      | (X5)<br>COMPLETE<br>DATE |
| D 367   | Continued From pa   | ge 152   | D 367               |  | -          |                          |
|   | -The eMARs were t   | to be checked daily by the DRC and changes were to be  |                     |  |            |                          |
|   | 01/16/19 revealed o   | ent #1's current FL-2 dated<br>diagnoses included<br>type 2 diabetes mellitus.   |                     |  |            |                          |
|   | 05/06/19 revealed a<br>(gastroenterologist)<br>used to cleanse the                        | #1's physician's orders dated<br>a medication order from her GI<br>for GoLytely (a medication<br>colon prior to a colonoscopy)<br>stituted; use as directed for  |                     |  |            |                          |
|   | referral form" revea<br>order from Residen<br>on 05/20/19 for "Ga<br>to cleanse the color | #1's "medical or emergency<br>aled the facility requested an<br>it #1's Nurse Practitioner (NP)<br>aviLyte-G (a medication used<br>in prior to a colonoscopy) to<br>done" and the NP had signed<br>19. |                     |  |            |                          |
|   | physician on 07/24/<br>-Resident #1 had b<br>colonoscopy by her                           | v with Resident #1's GI<br>'19 at 9:41am revealed:<br>een referred to him for a<br>Primary Care Provider (PCP).<br>#1 for a consultation on  |                     |  |            |                          |
|   | -An order for GoLyt<br>transportation drive<br>the day of Resident                        | rely was provided to the<br>or and faxed to the facility on<br>the #1's initial consultation on<br>the facility again on<br>and 07/15/19.  |                     |  |            |                          |
|   | Medication Adminis<br>revealed:<br>-There was no entr                                     | t #1's May 2019 Electronic<br>stration record (eMAR)<br>y for GoLytely to be<br>/05/19 prior to the 05/06/19   |                     |  |            |                          |

Division of Health Service Regulation

|  |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                         | (X2) MULTIPL        | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
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| AND PLAN                                       | OF CORRECTION  | IDENTIFICATION NOMBER.  | A, BUILDING:        |  | COIVIP                        | relen                    |
|  |  | HAL060149   | B. WING             |  | 07/2                          | 9/2019                   |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |                               |                          |
| EAST TO  | WNE  |   |                     | NAMITY ROAD  |                               |                          |
|  |  |   | TTE, NC 282         |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG                       | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE                         | (X5)<br>COMPLETE<br>DATE |
| D 367  | Continued From pa  | ge 153  | D 367               |  |                               |                          |
|  | -  | _   |                     |  |                               |                          |
|  | scheduled colonose -There was no entr  |   |                     |  |                               |                          |
|  |  | /19/19 prior to the 05/20/19  |                     |  |                               |                          |
|  | scheduled colonos  |   |                     |  |                               |                          |
|  |  | y for GaviLyte-G (generic for   |                     |  |                               |                          |
|  | GoLytely) to be adn  | ninistered at 8:00am on   |                     |  |                               |                          |
|  | •  | mentation it had not been   |                     |  |                               |                          |
|  | administered.  |   |                     |  |                               |                          |
| Telephone interview with a representative from |  |   |                     |  |                               |                          |
|  | the facility's contracted pharmacy on 07/25/19 at 10:37am revealed:  -The facility faxed physician's orders to the |   |                     |  |                               |                          |
|  |  |   |                     |  |                               |                          |
|  |  |   |                     |  |                               |                          |
|  | pharmacy.  | •   |                     |  |                               |                          |
|  | -The pharmacy ent  | ered the orders into the eMAR   |                     |  |                               |                          |
|  | system.  |   |                     |  |                               |                          |
|  |  | ed a start date, the pharmacy   |                     |  |                               |                          |
| ,  |  | dication onto the eMAR for  |                     |  |                               |                          |
|  | that date.   | provide a start date, the   |                     |  |                               |                          |
|  |  | iter the medication onto the  |                     |  |                               |                          |
|  | eMAR for the follow  |   |                     |  |                               |                          |
|  |  | rder was new, the facility had  |                     |  |                               |                          |
|  | to go into the eMAF  | R system and approve it before  |                     |  |                               |                          |
|  | it would populate o  | nto the eMAR for  |                     |  |                               |                          |
|  | administration.  |   |                     |  |                               |                          |
|  |  | not receive Resident #1's   |                     |  |                               |                          |
|  |  | 19 or 05/06/19 for GoLytely.<br>ered Resident #1's GoLytely                   |                     |  |                               |                          |
|  |  | 05/22/19 onto the eMAR for the  |                     |  |                               |                          |
|  |  | 3/19) because it did not have a   |                     |  |                               |                          |
|  | start date.  |   |                     |  |                               |                          |
|  |  | e ability to adjust dates and   |                     |  |                               |                          |
|  |  | administration, if necessary,   |                     |  |                               |                          |
|  |  | nistration of the GoLytely with   |                     |  |                               |                          |
|  | the scheduled colo   | noscopy.  |                     |  |                               |                          |
|  | Interview with the l   | ead Medication Aide   |                     |  |                               |                          |
|  |  | ident Care Coordinator (RCC)  |                     |  |                               |                          |
|  | on 07/24/19 at 12:4  |   |                     |  |                               |                          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                     | (X3) DATE SURVEY<br>COMPLETED  |         |                          |
|--|---|--|---------------------|--|---------|--------------------------|
|  |   | HAL060149  | B. WING             |  | 07/2    | 29/2019                  |
| NAME OF  | PROVIDER OR SUPPLIER  |  | DRESS. CITY, §      | STATE, ZIP CODE  | <u></u> |                          |
|  |   |  |                     | NAMITY ROAD  |         |                          |
| EAST TO  | OWNE  |  | TE, NC 282          |  |         |                          |
| (X4) ID<br>PREFIX<br>TAG   | IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH'CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE   | (X5)<br>COMPLETE<br>DATE |
| D 367  | Continued From pa   | ge 154   | D 367               |  |         |                          |
|  | -She did not know is a colonoscopy on 0 -Whomever receives at Resident #1's GI have faxed the order the colonoscopy da -She did not know is administered GoLyt was not on the eMA-She did not know is GoLytely dated 05/0 pharmacy so that it and administered the colonoscopy appoirties would have been GoLytely order to the RCC at that time. Interview with the R revealed: -The RCC was respected to the pharmacy and the eMAR system apharmacyShe had the capable times of administration needed so medication be administered basefor the colonoscopy.  A second interview is Coordinator (RCC) revealed: -She was responsible monthlyShe would compared. | Resident #1 was scheduled for 15/06/19. The determinant of the pharmacy and given the to the pharmacy and given the to the RCC at that time. Resident #1 was not tely on 05/19/19 because it AR. Why Resident #1's order for 06/19 had not been sent to the could be added to the eMAR needay prior to her 05/20/19 hatment. The responsibility to fax the ne pharmacy because she was e.  RCC on 07/25/19 at 2:33pm  Consible for faxing new orders in after they were entered by the oility of adjusting dates and tion in the eMAR system if ions such as GoLytely could seed on the appointment date of the resident Care on 07/29/19 at 11:46am  Dele for auditing eMARs once the the resident's most recent of the resident's most recent. | <i>D</i> 301        |  |         |                          |
|  | FL2 or physician ordensure dosages and  | der sheet to their eMAR to<br>d frequency of administration<br>he would also ensure any  |                     |  |         |                          |
|  |   | ng physician notification had  |                     |  |         |                          |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION           | (X3) DATE SURVEY<br>COMPLETED  |      |                          |
|--|---|--|--------------------------|--|------|--------------------------|
|  |   | HAL060149  | B. WING                  |  | 07/2 | 9/2019                   |
| NAME OF I  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S           | STATE, ZIP CODE  |      |                          |
| EAST TO  | OWNE  |  | TH SHARON<br>TTE, NC 282 | NAMITY ROAD<br>105   |      |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE |
| D 367  | since the last FL2 of the eMAR because verified them in the have to be correct a audited.  Interview with the A 9:04am revealed: -She provided over The RCC was rest the pharmacy enter computer profileOnce the medicating facility, it was the R and approve the ordinary the pharmacyThe RCC was rest on the eMAR GoLy based on the date of appointmentGoLytely should not be administered to because she did not scheduled for 05/24-GoLytely should have available for adminition 05/19/19 for Reside A second interview 07/25/19 at 3:57pm aides (MA), the Reand the Director of responsible for chedaily.  3. Review of Residents. | are any new orders received or physician's order sheet to she thought if she had computer system, they would and would not need to be dministrator on 07/25/19 at sight to the RCC. consible for sending orders to ered orders into a resident's on was dispensed to the CC's responsibility to verify der entered onto the eMAR by consible for entering the date tely should be administered of the colonoscopy of the colonoscopy of the entered on the eMAR to Resident #1 on 05/23/19 of the entered on the eMAR and istration on 05/05/19 and ent #1.  with the Administrator on a revealed the medication sident Care Coordinator (RCC) Resident Care (DRC) were cking eMARS for accuracy | D 367                    |  |      |                          |
| L  | 01/16/19 revealed   | diagnoses included   |                          |  |      |                          |

Division of Health Service Regulation

|                          | OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BUILDING:            |  | (X3) DATE SURVEY COMPLETED |                          |
|--------------------------|---|--|-------------------------|--|----------------------------|--------------------------|
|                          |   | HAL060149  | B. WING                 |  | 07/2                       | 9/2019                   |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, S          | STATE, ZIP CODE  |                            |                          |
| EAST TO                  | OWNE  |  | TH SHARON<br>TE, NC 282 | NAMITY ROAD<br>205   |                            |                          |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                            | (X5)<br>COMPLETE<br>DATE |
| D 367                    | Continued From pa   | ge 156   | D 367                   |  | <u>.</u>                   |                          |
|                          | Parkinson's disease   | e and major depression.  |                         |  |                            |                          |
|                          | 04/12/19 revealed a<br>(gastroenterologist)<br>used to cleanse the  | #8's physician's orders dated<br>a medication order from her Gl<br>for GoLytely (a medication<br>colon prior to a colonoscopy)<br>tituted; use as directed for |                         |  |                            |                          |
|                          | Review of Resident #8's "medical or emergency referral form" revealed the facility had requested an order from Resident #1's Nurse Practitioner (NP) on 05/20/19 for "GaviLyte-G (a medication used to cleanse the colon prior to a colonoscopy) to have colonoscopy done" and the NP had signed the order on 05/22/19.   |  |                         |  |                            |                          |
|                          | Telephone interview with Resident #8's GI physician's Medical Assistant on 07/25/19 at 11:22am revealed: -Resident #8 had been referred to GI for a colonoscopy by her Primary Care Provider (PCP)Resident #8 had been seen by the GI on 04/12/19 for a consultationAn order for GoLytely was provided to the transportation driver and faxed to the facility on the day of Resident #8's initial consultation on 04/12/19 and faxed to the facility again on 05/06/19, 05/13/19, and 07/15/19. |  |                         |  |                            |                          |
|                          | Medication Adminis revealed: -There was no entry administered on 05, scheduled colonosc -There was no entry administered on 05, scheduled colonosc  | /02/19 prior to the 05/03/19<br>copy.<br>y for GoLytely to be<br>/12/19 prior to the 05/13/19  |                         |  |                            |                          |

PHEM11

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED   |        |                  |
|--|---|--|----------------|---|--------|------------------|
|  |   | HAL060149  | B, WING        |   | 07/2   | 9/2019           |
| NAME OF  | PROVIDER OR SUPPLIER  |  | DRESS, CITY, S | STATE, ZIP CODE   | 1 4114 |                  |
| EAST TO  | OWNE  |  | TH SHARON      | NAMITY ROAD   |        |                  |
| (X4) ID  | SUMMARY STA   | TEMENT OF DEFICIENCIES   | ID             | PROVIDER'S PLAN OF CORRECTI   | ON     | (X5)             |
| PREFIX<br>TAG  | (EACH DEFICIENCY<br>REGULATORY OR L   | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) |        | COMPLETE<br>DATE |
| D 367  | Continued From pa   | ge 157   | D 367          |   |        |                  |
|  |   | ninistered on 05/23/19 at<br>entation it had not been  |                |   |        |                  |
|  | revealed there was solution GaviLyte-G  | #8's July 2019 eMAR<br>an entry for the bowel prep<br>to be administered on<br>with documentation it had |                |   |        |                  |
|  | Telephone interview with a representative from the facility's contracted pharmacy on 07/25/19 at 10:37am revealed:  -The facility faxed physician's orders to the pharmacy.  -The pharmacy entered the orders into the eMAR |  |                |   |        |                  |
|  | would enter the me that date.   | ed a start date, the pharmacy<br>dication onto the eMAR for  |                |   |        |                  |
|  | pharmacy would er eMAR for the follow   |  |                |   |        |                  |
|  |   | rder was new, the facility had<br>R system and approve it before<br>nto the eMAR for                     |                |   |        |                  |
|  | -The pharmacy did<br>GoLytely order date<br>-The pharmacy ent   | ered Resident #8's GoLytely  |                |   |        |                  |
|  | following day (05/2) start date.  | (2/19 onto the eMAR for the 3/19) because it did not have a  |                |   |        |                  |
|  | times of scheduled  | e ability to adjust dates and administration, if necessary, nistration of the GoLytely with noscopy.     |                |   |        |                  |
|  | Interview with a sec<br>(MA) on 07/25/19 a  | cond shift Medication Aide<br>t 4:11pm revealed:   |                |   |        |                  |

|                          | IT OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE CONSTRUCTION |  | (X3) DATE SURVEY |                          |
|--------------------------|--|---|----------------------------|--|------------------|--------------------------|
| AND PLAN                 | OF CORRECTION  | IDENTIFICATION NUMBER:  | A. BUILDING:               |  | COMPLETED        |                          |
|                          |  | HAL06014 <del>9</del>   | B. WING                    |  | 07/2             | 9/2019                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, 8             | STATE, ZIP CODE  |                  |                          |
|                          | Nanie  |   |                            | NAMITY ROAD  |                  |                          |
| EAST TO                  | )WNE   | CHARLOT   | TE, NC 282                 | 205  |                  |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE             | (X5)<br>COMPLETE<br>DATE |
| D 367                    | Continued From pa  | ge 158  | D 367                      |  |                  |                          |
|                          | -She worked 7:00al was the only supern-She was very busy Resident #8's GoLy for administrationShe did not adminidocumented she habecause she was sometimes of 07/25/19 -The RCC was responded to the pharmacy and the eMAR system apharmacyShe had the capabilities of administratineeded, so medicate administered bat for the colonoscopyShe did not know the system of the system of the system of the system of th | m to 12:15am on 07/14/19 and visor on staff that day. visor the GoLytely but ad administered it probably to busy.  It is idented to the coordinator at 2:33pm revealed: consible for faxing new orders at approving those orders in after they were entered by the collity of adjusting dates and the collity of adjusting dates and the collity of a gold that is gold the could sed on the appointment date |                            |  |                  |                          |
|                          | 11:46am revealed: -She was responsit monthlyShe would compart FL2 or physician or ensure dosages an were correct, and sparameters requiring been reportedShe did not compassince the last FL2 of the eMAR because verified them in the   | with the RCC on 07/29/19 at ole for auditing eMARs once the resident's most recent der sheet to their eMAR to diffequency of administration he would also ensure any graphysician notification had are any new orders received or physician's order sheet to she thought if she had computer system, they would and would not need to be  |                            |  |                  |                          |

Division of Health Service Regulation

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | , ,                     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|---|---|-------------------------|--|-------------------------------|--------------------------|
|                          |   | HAL060149   | B. WING                 |  | 07/29/2019                    |                          |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S          | STATE, ZIP CODE  |                               |                          |
| EAST TO                  | OWNE  |   | TH SHARON<br>TE, NC 282 | NAMITY ROAD<br>105   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| D 367                    | Continued From pa   | ge 159  | D 367                   |  |                               |                          |
|                          | Interview with the A 9:04am revealed: -She provided over-The RCC was rest the pharmacyThe pharmacy ent computer profileOnce the medicati facility, it was the R and approve the or the pharmacyThe RCC was rest on the eMAR GoLy based on the date of appointment.  A second interview 07/25/19 at 3:57pm aides (MA), the Re and the Director of responsible for che daily.  4. Review of Residirevealed diagnoses failure (CHF), chroiled. | dministrator on 07/25/19 at sight to the RCC. consible for sending orders to ered orders into a resident's on was dispensed to the CC's responsibility to verify der entered onto the eMAR by consible for entering the date tely should be administered of the colonoscopy  with the Administrator on a revealed the medication sident Care Coordinator (RCC) Resident Care (DRC) were cking eMARS for accuracy  ent #4's FL2 dated 01/21/19 included congestive heart nic obstructive pulmonary |                         |  |                               |                          |
|                          | disease (COPD), h<br>diabetes.  | ypoxia, acute renal failure and   |                         |  |                               |                          |
|                          | 05/11/19 revealed a<br>U-100 insulin (a me  | ent #4's physician order on<br>an order for a Novolog flexpen<br>edication used to control<br>ar), 8 units three times a day  |                         |  |                               |                          |
|                          | 06/19/19 revealed   | nt #4's physician order on<br>an order for a Novolog flexpen<br>nits three times a day with   |                         |  |                               |                          |

Division of Health Service Regulation

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ HAL060149 B. WING 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 367 Continued From page 160 D 367 Review of Resident #4's June 2019 electronic Medication Administration Record (eMAR) from 06/19/19 through 06/25/19 revealed: -There was an entry for Novolog flexpen, 8 units three times a day with meals, to be administered at 7:00am, 12:00pm and 5:00pm. -There was documentation Novolog flexpen 8 units was administered daily at 7:00am, 12;00pm and 5:00pm from 06/19/19 through 06/25/19. -There was an entry for a Novolog flexpen 10 units to be administered three times a day with meals at 6:30am, 11:30am and 4:30pm. -There was documentation Novolog 10 units was administered three times a day at 6:30am. 11:30am and 4:30pm from 06/19/19 through 06/25/19. -For seven days there were 2 entries on the June 2019 eMAR, from 06/19/19 through 06/25/19, for a Novolog flexpen, 8 units and 10 units, to be administered three times a day with meals... Interview with the lead Medication Aide/previous Resident Care Coordinator (RCC) on 07/24/19 at 10:48am revealed: -She was the RCC until 07/08/19. -She had received no training on those processes when she began working. - "No one explained the eMAR system to me". -There was no process to review the eMARs for accuracy. -She was not sure who discontinued the Novolog

eMAR.

Division of Health Service Regulation

8 units three times a day with meals, or why it

Interview with the first shift Medication Aide (MA)

-She administered the medications on her medication cart when they appeared on the

continued on the eMAR for 7 days.

on 07/24/19 at 11:15am revealed:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |         |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|---|---|---------|--|-------------------------------|--------------------------|
|  |   | HAL060149   | B. WING |  | 07/2                          | 9/2019                   |
| NAME OF  | PROVIDER OR SUPPLIER  | 4815 NOR  |         | STATE, ZIP CODE N AMITY ROAD   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG   | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |   |         | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE                         | (X5)<br>COMPLETE<br>DATE |
| D 367  | -She can not view padministrationShe did not notice eMAR and 2 differe for Novolog insulin 06/25/19She administered tinsulin, 10 units, to Telephone interview pharmacy on 07/24-Orders received by physician were entered from the physicianThe pharmacy con interface with the farmacy staffThe physician's ordunits to be administ meals was entered the pharmacy staffThe default time for indicated by the phyllt was the responsibility adjust the times as Interview with the Drophy on 07/25/19She did not review she thought the ReaccuracyShe did not know with the Drophy of 19. | there were 2 entries on the nt dosages for administration from 06/19/19 through the 7:00am dose of Novolog Resident #4.  with the facility's contracted /19 at 3:30pm revealed: with a the pharmacy from a fered on the eMAR. discontinued, the pharmacy to have a discontinue order inputer system does not cility's computer software. The ement staff could discontinue are for Novolog flexpen 10 fered three times a day before on the eMAR on 06/19/19 by | D 367   |  |                               |                          |

Division of Health Service Regulation STATE FORM

|                          | NT OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPL        | E CONSTRUCTION   | (X3) DATE SURVEY |                          |
|--------------------------|---|--|---------------------|--|------------------|--------------------------|
| AND PLAN                 | OF CORRECTION   | IDENTIFICATION NUMBER:   | A. BUILDING:        |  | COMP             | LETED                    |
|                          |   | HAL060149  | B. WING             |  | 07/2             | 9/2019                   |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |                  | <del>-</del> "           |
| EAST TO                  | NAME:   | 4815 NOR   | TH SHARO            | NAMITY ROAD  |                  |                          |
| EAST TO                  | DAAINE  | CHARLO   | ΓΤΕ, NC 282         | 205  |                  |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE             | (X5)<br>COMPLETE<br>DATE |
| D 367                    | Continued From pa   | ige 162  | D 367               |  |                  | -                        |
| D 367                    | -She reviewed new approving the entry-She did not review existing ordersShe did not know to documented as adrunits on the eMAR 06/25/19.  Interview with the A 4:20pm revealed: -The lead MA was to she did not receive step downThe eMARs were to MAs, RCC, and the made as needed.  b. Review of Resided dated 06/06/19 revealed: -There was an entry be administered datthrough 07/23/19There was documented daily a through 07/23/19Incruse Ellipta was | orders on the eMAR before  | D 367               |  |                  |                          |
|                          | administration on 0   | dications available for<br>7/23/19 at 2:55pm revealed:<br>use Ellipta hand held device |                     |  |                  |                          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |   | E CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED   |      |                  |
|---|---|---|----------------|---|------|------------------|
|   |   | HAL060149   | B. WING        |   | 07/2 | 9/2019           |
| NAME OF   | PROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY, S | STATE, ZIP CODE   |      | <u></u>          |
| EAST TO   | WNE   |   | TH SHARON      | N AMITY ROAD  |      |                  |
| (X4) ID   | SUMMARY STA   | TEMENT OF DEFICIENCIES  | ID             | PROVIDER'S PLAN OF CORRECTION   | ON.  | (X5)             |
| PREFIX<br>TAG   | (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE | COMPLETE<br>DATE |
| D 367   | Continued From pa   | ge 163  | D 367          |   |      |                  |
| D 367   | inside a plastic bag pharmacy label.  -The dispense date and the handwritter.  -There were 30 dos administered.  -The number 12 wa counter, indicating administered, and 1 administered since.  Telephone interview pharmacy on on 07.  -Resident #4 had ar for Incruse Ellipta 6 mouth daily.  -The pharmacy disp with a physician's or request, when the rather the medication had.  -One Incruse Ellipta the facility and there device.  -Resident #5's last on 06/06/19.  -No further requests Ellipta were receive pharmacy.  -The starting dose with the dose counter windone administration by 1.  -If Resident #4 was | with a computer generated on the label was 06/06/19 open date was 06/06/19 des in the device to be as displayed on the dose 12 doses were left to be as doses had been 06/06/19.  with the facility's contracted /24/19 at 3:30pm revealed: a active order dated 06/06/19 2.5mcg, inhale 1 puff by  bensed inhalers for residents order and at the facility's nedication was completed or expired a inhaler was sent each time to be were 30 doses in each  Incruse Ellipta was dispensed as from the facility for Incruse d or dispensed from the was identified as "30" in the w. In will bring this number down receiving daily doses of the should have completed the | D 367          |   |      |                  |
|   | 07/25/19 at 10:40ar<br>-She administered t  | dication aide (MA) on<br>m revealed:<br>the Incrusa Ellipta breathing<br>ent #4 when she worked on  |                |   |      |                  |

Division of Health Service Regulation

| AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/GLIA  IDENTIFICATION NUMBER: |  | 1 ` ′  |                     | COMPLETED   |            |                          |
|---|--|--|---------------------|---|------------|--------------------------|
|   |  | HAL060149  | B. WING             |   | 07/29/2019 |                          |
| NAME OF I   | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S      | TATE, ZIP CODE  |            |                          |
| EAST TO   |  | 4815 NOF   |                     | I AMITY ROAD  |            |                          |
|   | CUMMA DV CTA   |  | •                   | PROVIDER'S PLAN OF CORRECTI   | ON         |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE      | (X5)<br>COMPLETE<br>DATE |
| D 367   | Continued From pa  | ge 164   | D 367               |   |            |                          |
| D 367   | this medication cart-She did not put the that the device was-She did not know his should last-she thoushed did not usually-When she did assisure the medication check to see how minhalers.  Interview with the D (DRC) on 07/25/19-She has been reviet for complianceThe Resident Care overseeing the medication carts in She expected the RCC if there was a She expected the RCC if there was a she expected the medications as order practitionerShe did not know to doses administered c. Review of Resided dated 05/21/19 reved diskus blister with conhale one puff into Review of Resident Medication Adminis 07/01/19 through 0 | e open date on the plastic bag in.  now long the medication ught 30 or 45 days.  assist with cart audits, she made a was on the cart but did not hany doses were left with the director of Resident Care at 3:20pm revealed: ewing the resident's records are coordinator (RCC) had been dications, the medication carts are the process used to audit the this facility.  MAs to report to her or the problem with medications.  MAs to administer the ered by the licensed  the Incruse Ellipta had 18 in 48 days.  The series of the series of the lungs twice a day.  The series of the series of the lungs twice a day.  The series of the series of the lungs twice a day.  The series of the series of the lungs twice a day.  The series of the series of the lungs twice a day. | D 367               |   |            |                          |
|   | puff twice a day, to and 8:00pm.   | be administered at 8:00am<br>entation Advair diskus inhale 1   |                     |   |            |                          |

Division of Health Service Regulation

Division of Health Service Regulation

CTATUMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|---|--|--|-------------------------------|--------------------------|
|                          |  |   |  |  |                               |                          |
|                          |  | HAL060149   | B. WING                                  |  | 07/2                          | 9/2019                   |
| NAME OF I                | PROVIDER OR SUPPLIER   |   | ,  | STATE, ZIP CODE  |                               |                          |
| EAST TO                  | OWNE   |   | TE, NC 282                               | N AMITY ROAD<br>205  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| D 367                    | 8:00pm from 07/01, -There was an entry diskus administer a -There was an entry 250-50mcg, inhale administered at 8:0 07/12/19 through 0' -There was docume device had been ac 8:00pm from 07/12/ Observation of med at 2:55pm revealed -There was an Adva in a plastic bag with label and directions -There was a hand 07/04/19 on the pla -The dose counter or read "42"There was no Wixe medication cart.  Telephone interview pharmacy on on 07 -Resident #4 had a for Wixela 250-50m twice dailyThe pharmacy disp with a physician's or request, when the r the medication had -The facility was co that the generic inh place of the Advair -Wixela Inhaler was 07/12/19 for Reside | s administered at 8:00am and /19 through 07/12/19. y for the end date of Advair t 8:00pm on 07/12/19. y for Wixela blister with device, one puff twice a day, to be 0am and 8:00pm, from 7/24/19. entation Wixela blister with dministered at 8:00am and /19 through 07/24/19. dications on hand on 07/23/19: air diskus 250-50mcg device a computerized pharmacy -1 puff twice a day. written opened date of stic bag. window on the Advair diskus ela blister with device on the v with the facility's contracted /24/19 at 3:30pm revealed: n active order dated 07/12/19 acg, inhale 1 puff by mouth pensed inhalers for residents reder and at the facility's medication was completed or expired ntacted and it was explained aler (Wixela) would be sent in diskus for insurance reasons. is sent to the facility on | D 367                                    |  |                               |                          |
| Shilatan af II           | alth Service Regulation  |   | <u> </u>                                 | 1  |                               |                          |

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | [ ' '   | E CONSTRUCTION      | COMPLETED  |               |
|---|--|---|---------------------|--|---------------|
|   |  | HAL060149   | B. WING             |  | 07/29/2019    |
| NAME OF I                                     | PROVIDER OR SUPPLIER   | STREET AD   | DRESS CITY.         | STATE, ZIP CODE  |               |
| EAST TO                                       |  | 4815 NOR  |                     | N AMITY ROAD   |               |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE COMPLETE |
| D 367   | Continued From pa  | ge 166  | D 367               | ****   |               |
|   | Resident #4 was loc -She had not seen to -The pharmacist ha Wixela inhaler was diskusSince she had the a administered the Ac -She documented the Advair Diskus unde  | where the Wixela inhaler for<br>cated.<br>the Wixela inhaler.<br>d conveyed to the MA the<br>a generic form of the Advair<br>Advair diskus on the cart, she |                     |  |               |
|   | Interview with the Administrator on 07/25/19 at 9:04am revealed:  -The RCC was responsible for sending orders to the pharmacy.  -The pharmacy entered orders into a resident's computer profile.  -Once the medication was dispensed to the facility, it was the RCC's responsibility to verify and approve the order entered onto the eMAR by the pharmacy  -The eMARs were to be checked daily by the MAs, RCC, and the DRC and changes were to be made as needed.  -She did not know the MAs were administering Advair breathing treatments and documented Wixela breathing treatments were administered. |   |                     |  |               |
|   | CORRECTION DAT<br>DEFICIENCY SHAL<br>SEPTEMBER 1, 20   |   |                     |  |               |
| D 375   | 10A NCAC 13F .100<br>Medications   | 05(a) Self-Administration Of  | D 375               | 10A NCAC 13F .1005(a) Self-Admir<br>of Medicaitons   | istration     |
|   | 10A NCAC 13F .100  | 05 Self -Administration Of  |                     |  |               |

PRINTED: 08/12/2019 FORM APPROVED Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A, BUILDING: \_\_ B. WING HAL060149 07/29/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 375 Continued From page 167 D 375 Continued from page 167 Facility ED, RCC, and/ or DRC Medications will assure that residents who self-(a) An adult care home shall permit residents 8/26/19 administer their medications have an who are competent and physically able to physicians order in place, self-administer their medications if the following requirements are met: Facility ED, RCC and/or DRC (1) the self-administration is ordered by a will assure that any medications physician or other person legally authorized to 8/26/19 which are ordered as self-administer have prescribe medications in North Carolina and specific instructions for administration printed documented in the resident's record; and on the medication label (2) specific instructions for administration of prescription medications are printed on the Facility will assess any resident who medication label. request to self administer medications 8/26/19 to assure resident understands orders and is physically able to self-administer Self-adminstation assessment will be completed by ED, RCC, and/or DRC. This Rule is not met as evidenced by: 8/26/19 Assessment tool will be filed in residents Based on observations, record reviews, and record. interviews, the facility failed to assure 1 of 5 sampled residents with an order for a hand held Self-administer assessment tool will be inhaler, used to treat shortness of breath (SOB), reviewed with residents Primary Care Provider( 8/26/19 had a physician's order to self administer the PCP).Contact with residents PCP will be medication, (Resident #4). documented. The findings are: Residents who have orders to self 8/26/19 administer medications will be Review of Resident #4's current FL2 dated reassessed quarterly by ED, RCC, 01/21/19 revealed diagnoses included congestive and/or DRC heart failure (CHF), chronic obstructive pulmonary disease (COPD), hypoxia, acute renal failure and diabetes. Review of Resident #4's physician order on 06/19/19 revealed an order for Albuterol Sulfate

Division of Health Service Regulation

inhaler, 90mcg, inhale 2 puffs every 4-6 hours as

Review of Resident #4's June and July 2019 electronic medication administration record (eMAR) from 06/19/19 through 07/24/19

needed for shortness of breath.

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING:  |                           |   | X3) DATE SURVEY<br>COMPLETED |                          |
|--|---|---|---------------------------|---|------------------------------|--------------------------|
|  |   | HAL060149   | B. WING                   |   | 07/:                         | 29/2019                  |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S            | TATE, ZIP CODE  |                              |                          |
| EAST TO  | OWNE  |   | RTH SHARON<br>TTE, NC 282 | I AMITY ROAD<br>05  |                              |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE                       | (X5)<br>COMPLETE<br>DATE |
| D 375  | 90mcg, inhale 2 put 4-6 hours as neede -There was no docu inhaler was adminis 07/24/19.  Observation of the r Resident #4 on 07/2 Albuterol inhaler was administration.  Interview with the fir on 07/23/19 at 2:55 -Resident #4 kept th person to self admin breathThe MA did not kee medication cartResident #4 did no other medicationsResident #4 did no used the Albuterol ir -There was no docu frequency of usage Interview with Resid revealed: -He kept the albuter pouch on the back of -He used the inhale breathHe did not report to the inhalerHe did not know he albuterol inhaler ever | y for Albuterol Sulfate inhaler ffs, to be administered every d for shortness of breath. Immentation the Albuterol stered from 06/19/19 through medications on hand for 23/19 at 2:55pm revealed the is not available for ret shift Medication Aide (MA) pm revealed: The Albuterol inhaler on his hister when he felt short of the Albuterol inhaler on the t self administer any of his t report to the MAs when he shaler. Immentation of Resident #4's for the Albuterol inhaler. Ident #4 on 07/23/19 at 1:05pm are landheld inhaler in a clother short of handheld inhaler in a clother short of handheld inhaler in a clother for the Albuterol inhaler. | D 375                     |   |                              |                          |

Division of Health Service Regulation STATE FORM

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | E CONSTRUCTION          | (X3) DATE SURVEY<br>COMPLETED   |            |                          |
|--|--|--|-------------------------|---|------------|--------------------------|
|  |  | HAL060149  | B. WING                 |   | 07/29/2019 |                          |
| NAME OF I  | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S          | TATE, ZIP CODE  |            | <del>=</del>             |
| EAST TO  | OWNE   |  | TH SHARON<br>TE, NC 282 | I AMITY ROAD  |            |                          |
| (VA) ID  | SUMMARY STA  | TEMENT OF DEFICIENCIES   | ID ID                   | PROVIDER'S PLAN OF CORRECTI   | ON         | (VE)                     |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG           | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE      | (X5)<br>COMPLETE<br>DATE |
| D 375  | Continued From pa  | ge 169   | D 375                   |   |            |                          |
|  | in the cloth bag.  | held Albuterol sulfate inhaler<br>have Resident #4's name on<br>directions for proper  |                         | •   |            |                          |
|  | Review of the facility's policy and procedure for Resident Self-Administration of Medications revealed: -Residents would meet the following requirements for self administration of medications: -The resident would be competent and physically ableThe resident would have an order by a physician to self administer, and kept in the resident's recordSpecific instructions for administration of the medication would be printed on the labelThe physician would be notified if a resident had a change in mental or physical ability or was non compliant with the physicians orders or facilities |  |                         |   |            |                          |
|  | on 07/23/19 at 1:35 -The PCP had pres needed for shortner -Resident #4 also we nebulizer treatment needed for shortner -The Albuterol inhal times the resident le experience shortner -The Albuterol inhal in the facilityThe PCP had not get o self administer the  | cribed the Albuterol inhaler as ss of breath for Resident #4.  vas prescribed an Albuterol, administered with a mask, as ss of breath  ler was prescribed for the eft the facility and may |                         |   |            |                          |

| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205  [ACA) ID PREFEIX TAG  CONTINUES  SUMMARY STATEMENT OF DEFICIENCIES.  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  COMPLETE TAG  CROSS-REFERENCE TO THE APPROPRIATE DATE  D 375  Continued From page 170  the MA should administer the Albuterol nebulizing treatment with the mask for maximum effectiveness.  -Due to Resident #4's diagnoses, the PCP would want to review the eMARs to determine how often Resident #4 was requesting prn breathing treatments.  -He did not know Resident #4 was self administering the Albuterol inhaler.  Interview with the RCC on 07/25/19 at 4:10pm revealed: -She had been implementing and training the MAs to audit their carts weeklyShe also had been auditing the medication carts herselfShe verified the resident's physician order summary with the resident's medications on the cartShe did not know Resident #4 was self administering his Albuterol inhalerShe does not know why that was not observed during an audit of Resident Care (DRC) on 07/25/19 at 3:20pm revealed: -The RCC had been overseeing the medications, the medication carts and the ordersShe did not know the process used to audit the   | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE<br>A. BUILDING:   | E CONSTRUCTION |  | (X3) DATE SURVEY<br>COMPLETED |          |
|--|--|---|---|----------------|--|-------------------------------|----------|
| EAST TOWNE  SUMMARY STATEMENT OF DEPICIENCES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 375  Continued From page 170 the MA should administer the Albuterol nebulizing treatments with the mask for maximum effectiveness.  -Due to Resident #4's diagnoses, the PCP would want to review the eMARs to determine how often Resident #4 was requesting pro breathing treatments.  -He did not know Resident #4 was self administering the Albuterol inhaler.  Interview with the RCC on 07/25/19 at 4:10pm revealed:  -She had been implementing and training the MAs to audit their carts weekly.  -She also had been auditing the medication carts herself.  -She verified the resident's physician order summary with the resident's medications on the cart.  -She does not know Nesident #4 was self administering his Albuterol inhaler.  -She does not know why that was not observed during an audit of Resident #4's medications.  Interview with the Director of Resident Care (DRC) on 07/25/19 at 3:20pm revealed:  -The RCC had been overseeing the medications, the medication carts and the orders.  |  |   | HAL060149   | B. WING        |  | 07/2                          | 9/2019   |
| CHARLOTTE, NC 28205  (X4) ID  (X4) ID  (X5) ID  (X6) ID  (X70 ID | NAME OF  | PROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY, S | TATE, ZIP CODE   |                               |          |
| SUMMARY STATEMENT OF DEFICIENCIES   DEPOSITION   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION   CAGNECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    D 375   Continued From page 170   The MAS should administer the Albuterol nebulizing treatment with the mask for maximum effectiveness.   | EAST TO  | OWNE  |   |                |  |                               |          |
| the MA should administer the Albuterol nebulizing treatment with the mask for maximum effectiveness.  -Due to Resident #4's diagnoses, the PCP would want to review the eMARs to determine how often Resident #4 was requesting prn breathing treatments.  -He did not know Resident #4 was self administering the Albuterol inhaler.  Interview with the RCC on 07/25/19 at 4:10pm revealed:  -She had been implementing and training the MAs to audit their carts weekly.  -She also had been auditing the medication carts herself.  -She verified the resident's physician order summary with the resident's medications on the cart.  -She did not know Resident #4 was self administering his Albuterol inhaler.  -She does not know why that was not observed during an audit of Resident #4's medications.  Interview with the Director of Resident Care (DRC) on 07/25/19 at 3:20pm revealed:  -The RCC had been overseeing the medications, the medication carts and the orders.   | PRÉFIX   | (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL  | PREFIX         | (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR | JLD BE                        | COMPLETE |
| medication carts in this facilityShe expected the MAs to administer the medications as ordered by the licensed practitionerShe did not know the Resident #4 was self administering his Albuterol inhaler.  Interview with the Administrator on 07/25/19 at 4:20pm revealed: -The RCD and the RCC were responsible for the clinical aspects of the facility.  | D 375  | the MA should adm treatment with the reffectiveness.  -Due to Resident #4 want to review the Resident #4 was retreatments.  -He did not know Radministering the A Interview with the Revealed:  -She had been important their concording and additional managements.  -She did not know Radministering his Alabert the result.  -She did not know Radministering his Alabert the Management the Management of Recording an audit of Recording an audit of Recording an audit of Recording and the Management of Recording | inister the Albuterol nebulizing mask for maximum  A's diagnoses, the PCP would eMARs to determine how often questing prn breathing  esident #4 was self lbuterol inhaler.  CC on 07/25/19 at 4:10pm  lementing and training the arts weekly. In auditing the medication carts sident's physician order esident's medications on the Resident #4 was self lbuterol inhaler. In why that was not observed Resident #4's medications.  Director of Resident Care at 3:20pm revealed: In overseeing the medications, is and the orders. The process used to audit the this facility.  MAs to administer the ered by the licensed  The Resident #4 was self lbuterol inhaler.  Indicate the Resident #4 was self lbuterol inhaler. | D 375          |  |                               |          |

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|               | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  | ` '                     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                  |
|---------------|--|--|-------------------------|--|-------------------------------|------------------|
|               |  |  | A. BUILDING:            |  |                               |                  |
|               |  | HAL060149  | B. WING                 |  | 07/29/2019                    |                  |
| NAME OF F     | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S          | STATE, ZIP CODE  |                               |                  |
| EAST TO       | WNE  |  | TH SHARON<br>TE, NC 282 | NAMITY ROAD  |                               |                  |
| (X4) ID       | SUMMARY STA  | TEMENT OF DEFICIENCIES   | ID                      | PROVIDER'S PLAN OF CORRECTION  | ON I                          | (X5)             |
| PREFIX<br>TAG | (EACH DEFICIENCY   | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG           | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY)   | D BE                          | COMPLETE<br>DATE |
| D 375         | Continued From pa  | ge 171   | D 375                   |  |                               |                  |
|               | carts to be complet week.  -The completed car the RCC and herseShe had not review dateShe did not know ladministering his Al-She expected the as ordered by the process. | wed the current cart audits to Resident #4 was self Ibuterol inhaler as needed. MAs to administer medications ohysician. TE FOR THE STANDARD LL NOT EXCEED |                         |  |                               |                  |
| D 444         | 10A NCAC 13F .12<br>Requirements   | 08 (g) Death Reporting   | D 444                   |  |                               |                  |
|               | 10A NCAC 13F .12<br>Requirements   | 08 Death Reporting   |                         | 10A NCAC 13F .1208(g) Death Re<br>Requirements   | porting                       |                  |
|               | circumstances des<br>facility shall notify the<br>enforcement autho  | any resident death under<br>cribed in G.S. 130A-383, a<br>he appropriate law<br>rities so the medical examiner<br>ich the body is found may be             |                         | Facility will assure notification to al appropericate authorities. Documentation of notifications will maintained by the facility. |                               | 8/26/19          |
|               | notified. Documen<br>be maintained by th   | tation of such notification shall ne facility and be made by the Division upon request.  |                         | Facility ED and/or DRC will review incident/accident to ensure the cor agencies are notified as required.                          |                               | 8/26/19          |
|               | Based on interview facility failed to ass enforcement for 1 c  | et as evidenced by:<br>s and record reviews the<br>ure notification of local law<br>of 1 resident (Resident #9) who<br>insive on the bathroom floor.       |                         | Facitilty Med Aides have received provided by a Licensed RN on Inci Accident reporting   |                               | 8/26/19          |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | 1 ' '  | E CONSTRUCTION      | (X3) DATE<br>COMP  | SURVEY<br>PLETED |                          |
|--|--|--|---------------------|--|------------------|--------------------------|
|  |  | HAL060149  | B. WING             |  | 07/2             | 9/2019                   |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |                  |                          |
| EAST TO  | )WNF   |  |                     | N AMITY ROAD   |                  |                          |
| LAUTIC   | ,  | CHARLO   | TTE, NC 282         | 205  |                  |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE             | (X5)<br>COMPLETE<br>DATE |
| D 444  | Continued From pa  | ge 172   | D 444               | Continued from page 172  |                  |                          |
|  | 02/07/19 revealed of<br>diabetes, cerebral v<br>depression.  | #9's current FL2 dated<br>liagnoses included dementia,<br>rascular accident, and   |                     | Facility staff have received trainin proper documentation by a Licen   |                  | 8/26/19                  |
|  | #9 dated 06/25/19 a -The location of the bathroomThe incident was n -The type of injury v -First aid was docur "medics"The resident condi- unresponsive; "resident and   | vas documented as "no injury. mented as administered by tion was documented as dent has expired". the family were notified. umentation the local law |                     |  |                  |                          |
|  |  | #9's electronic progress note<br>:15am revealed "Resident<br>bathroom."  |                     |  |                  |                          |
|  | the medication aide 06/24/19 when Res unresponsive revea -She was unsure whon 06/24/19 around -The policy is when do CPR until EMS a over CPR.  -The residents were and documented or -She had charted in 5:15am "Resident p-Resident #9 was o | lled:<br>hat happened to Resident #9   |                     |  |                  |                          |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING:  |                     | (X3) DATE SURVEY<br>COMPLETED   |      |                          |
|--|---|--|---------------------|---|------|--------------------------|
|  |   |  | , , , DQ,LDING.     | <u> </u>  |      |                          |
|  |   | HAL060149  | B. WING             |   | 07/2 | 9/2019                   |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | TATE, ZIP CODE  |      |                          |
| EAST TO  | OWNE  |  |                     | AMITY ROAD  |      |                          |
|  | OLIMANDY OTA  |  | TE, NC 282          | PROVIDER'S PLAN OF CORRECTI   | ON   | (VE)                     |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE |
| D <b>4</b> 44  | Continued From pa   | age 173  | D 444               |   |      |                          |
|  | #9's] body." -"Maybe she choke -She did not think s law enforcement.  | she needed to contact the local  |                     |   |      |                          |
|  | revealed:   | call report dated 06/24/19   |                     |   |      |                          |
|  |   | t contacted EMS until 5:26 am.<br>entation there were no staff<br>ident #9.  |                     |   |      | ,                        |
|  | 07/29/19 at 3:30pm -He was dispatche of 06/24/19 for Res -He found Residen floor near the toilet -There was no staf   | d to the facility on the morning<br>sident #9.<br>t #9 laying on the bathroom  | ,                   |   |      |                          |
|  | 3:00pm revealed: -She completed an when Resident #9 gave it to the forme-She was not awar was to be called in unresponsive on the completed the present at the facil found unresponsives completed the former Administration. | e the local law enforcement regards to Resident #9 found he bathroom floor. e incident form but was not ity when Resident #9 was e on the floor. e incident report because the or requested she complete the |                     |   |      |                          |
|  | morning on 06/24/   | exactly what happened that<br>19 because each staff person<br>ry about the incident.   |                     |   |      |                          |

PHEM11

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: \_ B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE. TAG TAG DEFICIENCY) D 444 D 444 Continued From page 174 -She filled out the incident report but did not think to call the local law enforcement. Interview with the Resident Care Coordinator (RC) on 07/26/19 at 10:25 am revealed: -She was unsure why the local law enforcement were not notified. -She was unsure why there was no documentation by the MA that was working that morning. -The MA should contacted the local law enforcement when she found Resident #9 unresponsive on the bathroom floor. Interview with the Administrator on 07/26/19 at 11:45 am revealed: -She had been working in the facility since July 1, 2019. -She did not know the local law enforcement were not notified regarding Resident #9 found unresponsive on the bathroom floor. -She thought if Emergency Medicinal Services were contacted, they would be the ones to contact the local law enforcement, if they were needed. -She relied on her lead supervisor to follow up on all incidents reports and to contact the proper authority if needed for any death or injury. Telephone interview with the former Administrator on 07/29/19 at 12:1 revealed: -His last day as Administrator of this facility was 06/28/19. -The night shift MA called him on 06/24/19 between 4:30 am and 5:30am to report Resident #9 had expired. -He did not know if EMS had performed CPR

Division of Health Service Regulation

Resident #9's death.

because he did not receive a report from them. -The facility did not notify law enforcement of

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   | (X2) MULTIPLE CONSTRUCTION (XA. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|---|---|--|-------------------------------|--------------------------|
|                          |  | HAL060149   | B. WING                                   |  | 07/29/2019                    |                          |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |   | STATE, ZIP CODE  | 1 0772                        | 9/2019                   |
| EAST TO                  | WNE  |   | TH SHARON                                 | NAMITY ROAD  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)  | DBE                           | (X5)<br>COMPLETE<br>DATE |
| D 444                    | Continued From pa  | ge 175  | D 444                                     |  |                               | -                        |
|                          | REFER TO TAG 27 CORRECTION DA DEFICIENCY SHALL SEPTEMBER 1, 20   | TE FOR THE STANDARD<br>LL NOT EXCEED  |   |  |                               |                          |
| D 451                    | 10A NCAC 13F .12 and Incidents   | 12(a) Reporting of Accidents  | D 451                                     | 10A NCAC 13F .1212(a) Reporting Accidents and Incidents  | g of                          |                          |
|                          | Incidents  (a) An adult care high department of social incident resulting in accident or incident resident requiring revaluation, hospital | 12 Reporting of Accidents and ome shall notify the county al services of any accident or resident death or any tresulting in injury to a eferral for emergency medical lization, or medical treatment |   | Facility will notify the Department of Service of any accident or incident resulting in resident death or injury resident requiring referral for emergency medical evaluation, hospitalization, or meidcal treatment than first aid. | to a                          | 8/26/19                  |
|                          | other than first aid.  |   |   | All incident/accident reports will be<br>reviewed by ED and/or DRC to<br>ensure proper reporting and notific<br>as required  |                               | 8/26/19                  |
|                          |  | s and record reviews, the   |   | Divisional VP of Operations and/or<br>Divisional Director of Clinical Servi<br>will review incident and accident re<br>during facility visits  | ices                          | 8/26/19                  |
|                          | social services (DS<br>which resulted in de  | ure the county department of S) was notified of an incident eath to 1 of 1 sampled resident unresponsive on the out a pulse.  |   | Facility Medication Aide staff have training on incident and accident re<br>Training provided by a Licensed R  | eporting.                     | 8/26/19                  |
|                          | 02/07/19 revealed  | t #9's current FL2 dated<br>diagnoses included dementia,<br>vascular accident, and  |   | Facility Medication Aide staff have received training on documentation Licensed RN   |                               | 8/23/19                  |

Division of Health Service Regulation

STATE FORM

6899

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION          | (X3) DATE SURVEY<br>COMPLETED  |       |                          |
|--|---|--|-------------------------|--|-------|--------------------------|
|  |   | HAL060149  | B. WING                 |  | 07/2  | 9/2019_                  |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET ADI   | ORESS, CITY, S          | STATE, ZIP CODE  |       |                          |
| EAST TO  | OWNE  |  | TH SHARON<br>TE, NC 282 | NAMITY ROAD<br>105   |       |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE | (X5)<br>COMPLETE<br>DATE |
| D 451  | Continued From pa   | ge 176   | D 451                   |  |       |                          |
|  | Review of Accident #9 dated 06/25/19 a -The location of the bathroomThe incident was r -The type of injury v -First aid was docu "medics"The resident condi unresponsive; "resi -The physician and -There was no docu weas faxed to the land Review of Resident 06/24/19 at 5:15am away in the bathrood Interview with a rep county DSS on 04/ -There was no docu faxed incident repo unresponsive without emergency medica -She had not receive Reports related to land Interview with the Land 3:00pm revealed: -She completed an when Resident #9 gave it to the formet -It was the facility's representative of the | /Incident Reports for Resident at 10:03pm revealed: incident was in the resident's incident was in the resident's an witnessed. was documented as "no injury. mented as administered by ition was documented as dent has expired". the family were notified. umentation the incident report ocal county DSS. if #9's electronic notes dated in revealed "Resident passed om."  Incresentative from the local 18/19 a 10:02am revealed: umentation for receipt of a ref for Resident #9 regarding out a pulse requiring I evaluation on 04/24/19. I evaluation on 04/24/19. I evaluation on 07/25/19 at Incident Accident Report was found unresponsive and or Administrator. I policy to notify a see local county DSS through an ent report when a resident |                         |  |       |                          |
|  | Accident Reports to   | ole for faxing the Incident<br>the local county DSS.<br>ad sent the Incident Accident  |                         |  |       |                          |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPL<br>A. BUILDING:  | E CONSTRUCTION      | (X3) DATE<br>COMPI   | SURVEY<br>LETED |                          |
|--|--|---|---------------------|--|-----------------|--------------------------|
|  |  |   |                     | _  |                 |                          |
|  |  | HAL060149   | B. WING             |  | 07/2            | 9/2019                   |
| NAME OF  | PROVIDER OR SUPPLIER   |   | , ,                 | STATE, ZIP CODE  |                 |                          |
| EAST TO  | OWNE   |   | TE, NC 282          | NAMITY ROAD<br>195   |                 |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | ITEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE           | (X5)<br>COMPLETE<br>DATE |
| D 451  | Continued From pa  | ge 177  | D 451               |  |                 |                          |
|  | Report to the local<br>-She could not find<br>incident report for F<br>local DSS.  | county DSS.<br>the fax confirmation the<br>Resident #9 was sent to the  |                     |  |                 |                          |
|  | (RCC) on 07/26/19 -The lead Superviscompleting Incident faxing the report to -Incident and Accid   | ent reports were given to the   |                     |  |                 |                          |
|  | Administrator after they were completed.  Interview with the Administrator on 07/26/19 at 11:45am revealed: -She had been working in the facility since July 1, 2019The lead Supervisor and the Administrator were responsible for notifying the local county DSS of reports of incidents and accidentsIncident and Accident Reports were usually faxed or emailed to a representative of the local county DSSShe did not know the local county DSS had not been notified regarding Resident #9 found unresponsive.  |   |                     |  |                 |                          |
|  | Incident and Accide required anything of a the facility kept a when reports were anything that the facility kept a when reports were and fax confirmation documenting that the had been faxed to be anything the faxed to be anything to be anyth | ne local county DSS through an ent report when a resident other than first aide. copy of the fax confirmation sent to the local county DSS. on was available for review he incident report for 06/24/19 the local county DSS.  TE FOR THE STANDARD  LL NOT EXCEED |                     |  |                 |                          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1.   |                         |  | X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|--|-------------------------|--|------------------------------|--------------------------|
| 71131311  | OF CONTRACTOR  | DERTH OF HOW ROMDER.   | A. BUILDING:            |  | COMPLETED                    |                          |
|   |  | HAL060149  | B. WING                 |  | 07/29/2019                   |                          |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY,            | STATE, ZIP CODE  |                              |                          |
| EAST TO   | OWNE   |  | TH SHAROI<br>TE, NC 282 | N AMITY ROAD<br>205  |                              |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | D BE                         | (X5)<br>COMPLETE<br>DATE |
| D912  | Continued From pa  | ge 178   | D912                    |  | -                            | 7                        |
| D912  |  | eclaration of Residents' Rights  | D912                    | G.S 131D-21(2) Declaration of Res<br>Rights  | idents'                      |                          |
|   | 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. |  |                         | Facility will assure that residents recare and services which are adequappropriate, and in compliance with relevant federal and state laws and and regulations.  | ate,<br>า                    | 8/26/19                  |
|   |  |  |                         | Facility management structure has changed to ensure the delivery of conservices is in accordance with the Declaration of Resident Rights.  | been<br>care and             | 8/6/219                  |
|   |  | et as evidenced by:<br>ons, interviews and record<br>failed to assure every resident   |                         | Facility has implemented daily mor<br>stand-up meetings with all departn<br>heads.   |                              | 8/26/19                  |
|   | had the right to rece  | eive care and services which opriate and in compliance with  |                         | All department heads (managers) l<br>received training on Resident Righ  |                              | 8/26/19                  |
|   |  | tration, personal care,  |                         | Facility has implemented Manager<br>Duty (MOD) program.  | on                           | 8/26/19                  |
|   |  | ion, interviews, and record<br>ailed to provide personal care  |                         | Manager on Duty is set up to assur<br>Managers are available after norm<br>business hours, hoildays and on<br>weekends.  |                              | 8/26/19                  |
|   | assistance to 2 of 5<br>sampled related to o<br>post-surgical care a<br>[Refer to Tag 0269,  | residents (#2 and #5) colostomy care, bathing and fter a knee replacement. 10A NCAC 13F. 0901(a) Supervision (Type B                       |                         | Divisional VP of Operations, Divsional Director of Clinical Service and/or Divisional Business Manage conducted weekly visits, and rando interviews with residents to assure compliance of Resident Rights | er have                      | 8/26/19                  |
|   | reviews, the facility orders were implem   | ons, interviews, and record<br>failed to assure physicians'<br>lented for 3 of 7 sampled<br>s #1, #3, #8) related to<br>lons for scheduled |                         |  |                              |                          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                         | (X3) DATE SURVEY<br>COMPLETED  |               |                               |
|---|---|---|-------------------------|--|---------------|-------------------------------|
|   |   | HAL060149   | B. WING                 |  | 07/2          | 9/2019                        |
| NAME OF F   | PROVIDER OR SUPPLIER  | STREET ADD  |                         | STATE, ZIP CODE  |               |                               |
| EAST TO   | WNE   |   | TH SHARON<br>TE, NC 282 | NAMITY ROAD<br>05  |               |                               |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)                                 | D BE          | (X5)<br>COMPLETE<br>DATE      |
| D912  | Continued From pa   | ge 179  | D912                    | Continued from page 179  |               |                               |
|   | and blood pressure  | er stick blood sugar checks,<br>checks (#3). [Refer to Tag<br>3F. 0902(c)(4) Health Care  |                         | Facility ED, RCC, DRC and/or Des will conduct random interviewes wi residents any concerns will be add   | th<br>ressesd | 8/26/19                       |
|   |   | on, interviews and record alled to assure the required  |                         | Facility will continue conducting more resident council meetings   | onthly        | 8/26/19                       |
|   | staffing hours were met on first, second and third shifts (7:00am-3:00pm, 3:00pm to 11:00pm and 11:00pm-7:00am) based on a census of 69 -72 |   |                         | Concerns from meetings will be re-<br>and followed up on by managemen  |               | 8/26/19                       |
|   | residents, with 29 o<br>06/24/19 through 0  | f 49 shifts sampled from<br>7/14/19 understaffed. [Refer to<br>C 13F. 0606 Staffing Chart   |                         | Facility staff have received training<br>Residents Rights.<br>Training has been scheduled with<br>Ombudmans for 1st available Sept<br>2019     |               | 7/14/19<br>8/20/19<br>8/22/19 |
|   | reviews, the facility<br>referral and follow-u<br>for 4 of 7 sampled r<br>following up with a   | ons, interviews and record failed to assure healthcare up to meet the medical needs residents related to not cardiology and pulmonology bitalization for chest pain               |                         | Facility staff have received a copy<br>Declaration of Resident Rights<br>Facility will contined to provide on-<br>training on Residents Rights |               | 8/26/19                       |
|   | (Resident #2), not r<br>missed appointmen<br>an endocrinology conotifying the physiciappointments (Resi                                     | notifying the physician of a lit and delayed rescheduling of consult (Resident #3), and not lian of 3 missed colonoscopy idents #1 and #8). [Refer to NC 13F. 0902(b) Health Care |                         | Facility has ensured that Resident posters are posted in facility.   | Right         | 8/26/19                       |
| D914  | G.S. 131D-21 Dec  | eclaration of Residents' Rights   | D914                    | G.S 131d-21(4) Declaration of Resi<br>Rights   | idents'       |                               |
|   |   | I have the following rights:<br>ntal and physical abuse,<br>ation.  |                         | Facility will assure that residents a mental, physical abuse, neglect ar exploitation.   |               | 8/26/19                       |
|   |   |   |                         |  |               |                               |

6899

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING: \_\_\_\_\_ B. WING \_\_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETE<br>DATE |
|--------------------------|--|---------------------|--|--------------------------|
| D914                     | Continued From page 180  | D914                | Continued from pg 180  |                          |
|                          | This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents are free of neglect in compliance with federal and state laws and rules and regulations related Staffing, Personal Care and Supervision. |                     | Facility management structure has been changed to ensure the delivery of care and services is in accordance with the Declaration of Resident Rights.                                 | 8/26/19                  |
|                          | The findings are:  |                     | Facility has assured that the Delcaration of Resident Right and Resident Relations Posters are posted in facility with numbers available for all.                                    | 8/26/19                  |
|                          | Based on observation, interviews and record review, the facility failed to assure the required staffing hours were met on first, second and third shifts (7:00am-3:00pm, 3:00pm to 11:00pm and   |                     | Facility has implemented daily morning stand-up meetings with all department heads.  | 8/26/19                  |
|                          | 11:00pm-7:00am) based on a census of 69 -72 residents, with 29 of 49 shifts sampled from 06/24/19 through 07/14/19 understaffed.[Refer to tag 219, 10A NCAC 13F .0606 Staffing Chart   |                     | All department heads (managers) have received training on Resident Rights  | 8/26/19                  |
|                          | (Type A2 Violation).]  |                     | Facility has implemented Manager on Duty (MOD) program.  | 8/26/19                  |
|                          | Based on observation, interviews, and record review, the facility failed to provide personal care assistance to 2 of 5 residents (#2 and #5) sampled according to the care plans related to Resident #5 colostomy care and personal care                                     |                     | Manager on Duty is set up to assure<br>Management is available after normal<br>business hours, hoildays and on<br>weekends.  | 8/26/19                  |
|                          | and Resident #2 post-surgical care after a knee replacement.[Refer to tag 269,10A NCAC 13F. 0901(a) Personal Care and Supervision (Type A2 Violation).]  |                     | Divisional VP of Operations, Divsional Director of Clinical Services and/or Divisional Business Manager have conducted weekly visits, and random interviews with residents to assure | 8/26/19                  |
|                          | Based on observations, interviews, and record reviews, the facility failed to assure supervision was provided to 2 of 7 sampled residents (Resident #12 and #13) related to a resident with a history of substance abuse, found to have a                                    |                     | compliance of Resident Rights  |                          |
|                          | knife, beer and marijuana in his room, who returned to the facility on several occasions intoxicated and smelled of marijuana, frequently intimidated staff and residents, threatening and assaulting another resident (Resident #13), and a                                 |                     |  |                          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                         | (X3) DATE SURVEY<br>COMPLETED   |                                     |                                    |
|---|---|---|-------------------------|---|-------------------------------------|------------------------------------|
|   |   | HAL060149   | B. WING                 |   | 07/29                               | 9/2019                             |
| NAME OF I   | PROVIDER OR SUPPLIER  |   |                         | TATE, ZIP CODE  |                                     |                                    |
| EAST TO   | WNE   |   | TH SHARON<br>TE, NC 282 | I AMITY ROAD<br>05  |                                     | ***                                |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | .D BE                               | (X5)<br>COMPLETE<br>DATE           |
| D914  | Continued From pa   | ge 181  | D914                    | Continued from page 181   |                                     |                                    |
|   | #13, in the back co<br>threatened and ass<br>additional supervisi<br>the staff (Resident<br>NCAC 13F .0901(b                          | on the same hall as Resident<br>rner of the facility, who was<br>aulted by him, with no<br>on provided for her safety by<br>#12)[Refer to tag 270, 10A<br>) Personal Care and   |                         | Facility staff have received training<br>Residents Rights.<br>Training has been scheduled with<br>Ombudmans for 1st available Sept<br>2019  | ember 11t                           | 7/14/19<br>8/20/19<br>8/22/19<br>h |
|   | Supervision (Type /   | A2 Violation).] views and interviews, the   |                         | Facility staff have received a copy<br>Declaration of Resident Rights   | of                                  | 8/26/19                            |
|   | facility failed to resp<br>and in accordance<br>policy and procedu<br>(Resident #9) as ev<br>cardiopulmonary re<br>found unresponsive | oond to incidents immediately with the facility's established res for one resident sampled videnced by failing to perform esuscitation (CPR) who was e.[Refer to tag 271, 10A NCAC anal Care and Supervision                    |                         | Facility will contiued to provide on-<br>training on Residents Rights   | going                               | 8/26/19                            |
|   |   |   |                         | G.S 131D-25 Implementation  |                                     |                                    |
| D980  | this Article shall res<br>facility. Each facilit<br>training to staff to it   |   | D980                    | Facility will assure the managemer operations, and policies of the faciliare implemented and rules are maintained for personal care, supervision, referral and follow-up, health care implementation, medic administration, accuracy of the me administration records, resident rig self administering, reporting of inci accidents and death reporting | ation<br>dicaiton<br>hts, staffir   | 8/26/19<br>g                       |
|   | Based on other recand record reviews assure the manage of the facility were maintained for persand follow-up, hear                    | et as evidenced by: ON commendations, interviews, to the Administrator failed to ement, operations, and policies implemented and rules were sonal care, supervision, referral th care implementation, stration, accuracy of the |                         | Facility management structure has changed to ensure that all residen receive care and services which a adequate, appropriate and in com with all relevant federal and state and regulations, and facility policie procedures  | its<br>re<br>pliance<br>laws, rules | 8/26/19                            |

6899

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |  |   |                     |   | ATE SURVEY                          |                          |
|---|--|---|---------------------|---|-------------------------------------|--------------------------|
| AND PLAN  | OF CORRECTION  | IDENTIFICATION NUMBER:  | A. BUILDING:        |   | COMP                                | LETED                    |
|   |  |   |                     |   |                                     |                          |
|   |  | HAL060149   | B. WING             |   | 07/2                                | 9/2019                   |
| NAME OF I   | PROVIDER OR SUPPLIER   | STREET ADI  | ORESS, CITY, S      | STATE, ZIP CODE   |                                     |                          |
| EAST TO   | WNE  |   |                     | NAMITY ROAD   |                                     |                          |
| L., (O)   |  | CHARLOT   | TE, NC 282          | .05   |                                     |                          |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)   | D BE                                | (X5)<br>COMPLETE<br>DATE |
| D980  | Continued From pa  | ge 182  | D980                | Continued from page 182   |                                     |                          |
|   | (eMAR), resident ri  | orting of accidents and   |                     | Facility has implemented Manager<br>(MOD) program which consist of ke<br>management team members, to in<br>not limited to the following; ED, DR<br>Business Office Manager, Life Enri<br>Coordinator, and Dietary Manager   | ey<br>clude but<br>C, RCC           | 8/26/19                  |
|   | Interview with the Administrator on 07/26/19 at 11:45am revealed: -She started as the Administrator 3 weeks agoShe knew Resident #5 had a foul body odor around July 4, 2019 when Resident #5's family member contacted herShe did not know that staff were not assisting Resident #5 with colostomy care. |   |                     | Facility ED, RCC,DRC and/or othe management team members are crounds of facility no less than 3 times.  | ompleting                           | <sub>3</sub> 8/26/19     |
|   |  |   |                     | Facility ED, RCC,DRC and/or othe management team members are on "pop up" visits on different shifts to supervision/safety of residents  | ompleting                           | 9 8/26/19                |
|   | 10:20am revealed:  | dministrator on 07/29/19 at   |                     | Facility has implemented daily sta<br>meetings with all department head<br>(management team members).   |                                     | 8/26/19                  |
|   | scheduling since she RCCShe did not know to were not staffed acc.  Interview with the A 9:22am revealed, "initiate follow up pho"I'm working on that  Telephone interview responsible party or revealed: -There were so mathat "no one seems -When she came to weekends, she course.                       | v with Resident #2's<br>n 07/29/19 at 11:15am<br>ny changes in management<br>to care."<br>o visit after 5:00pm and on |                     | Divisional VP of Operations, Divsional Director of Clinical Servi and/or Divisional Business Manage conducted weekly visits, and rand interviews with residents to assure compliance of Resident Rights  Facility has completed trainings in following areas: -Residents Rights -Medicaiton Administration -Doucmentation -Facility Policies and Procedures -Personal Care -Personal Can and Supervision Colostomy Care, Observation, an -Accident/Incident Reporting -Resident Prep for Surgery (NPO) -Appointments -CPR | ger have<br>om<br>e<br>n all of the | 8/26/19                  |
|   | Non-compliance wa  | as identified at violation level in   |                     |   |                                     |                          |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   | E CONSTRUCTION      | (X3) DATE S<br>COMPL   |                   |                          |
|--|--|---|---------------------|--|-------------------|--------------------------|
|  |  | HAL060149   | B. WING             |  | 07/2              | 9/2019                   |
| NAME OF I  | PROVIDER OR SUPPLIER   | 4815 NOR  |                     | STATE, ZIP CODE  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | D BE              | (X5)<br>COMPLETE<br>DATE |
| D980   | reviews, the facility referral and follow-t for 4 of 7 sampled in following up with a consult after a hosp (Resident #2), not in missed appointment an endocrinology or notifying the physic appointments (Resident #2), not respond facility failed to respand in accordance policy and procedur (Resident #9) as excardiopulmonary refound unresponsive 13F .0901(c) Perso (Type A2 Violation).  3. Based on observiews, the facility were administered prescribing practitic observed during a second for the facility were administered prescribing practitic observed during a second for the facility were administered prescribing practitic observed during a second for the facility were administered prescribing practitic observed during a second for the facility were administered prescribing practitic observed during a second for the facility were administered prescribing practitic observed during a second for the facility were administered prescribing practitic observed during a second for the facility were administered prescribing practitic observed during a second for the facility were administered prescribing practitic observed during a second for the facility were administered prescribing practitic observed during a second for the facility and | reas: rations, interviews and record failed to assure healthcare up to meet the medical needs residents related to not cardiology and pulmonology bitalization for chest pain notifying the physician of a rand delayed rescheduling of consult (Resident #3), and not ian of 3 missed colonoscopy idents #1 and #8). [Refer to c 13F .0902(b) HealthCare Violation).]  reviews and interviews, the cond to incidents immediately with the facility's established res for one resident sampled videnced by failing to perform issuscitation (CPR) who was e.[Refer to tag 271, 10A NCAC anal Care and Supervision | D980                | Continued from page 183  Facility will provided ongoing train staff and/or new hires.  Documentation of all trainings/inseprovided will be maintained by factorial management has ensured that the are posted in the facility:  -Adult Care Home Bill of Rights -DHSR Compliant Line -Affinity Resident Relations Line -Affinity Human Resource Line | ervices<br>ility. | 8/26/19<br>8/26/19       |
|  | (Residents #10 and residents (Resident including a medical prior to a colonoscomedication used to medication used to artificial tears for di   | d #11) and 5 of 8 sampled ts #1, #3, #4, #8 and #13) tion used to clean the colon opy (Residents #1 and #8), a lower high cholesterol, a treat high blood pressure, and by eyes (Resident #3), a treat diabetes and two   |                     |  |                   |                          |

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D980 D980 Continued From page 184 medications used to prevent difficulty in breathing (Resident #4), a medication used as a muscle relaxant (Resident #10), a medication used to treat seizures and bipolar disorder (Resident #11) and a medication used for agitation (Resident #13). [Refer to tag 358, 10A NCAC 13F ,1004(a)] Medication Administration (Type A1 Violation),] 4. Based on observations, interviews, and record reviews, the facility failed to assure supervision was provided to 2 of 7 sampled residents (Resident #12 and #13) related to a resident with a history of substance abuse, found to have a knife, beer and marijuana in his room, who returned to the facility on several occasions intoxicated and smelled of marijuana, frequently intimidated staff and residents, threatening and assaulting another resident (Resident #13), and a resident who lived on the same hall as Resident #13. in the back corner of the facility, who was threatened and assaulted by him, with no additional supervision provided for her safety by the staff (Resident #12). [Refer to tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).1 5. Based on observations, interviews, and record reviews, the facility failed to assure physicians' orders were implemented for 3 of 7 sampled residents (Residents #1, #3, #8) related to preparation instructions for scheduled colonoscopies (Residents #1 and #8), medication administration, finger stick blood sugar checks, and blood pressure checks (Resident #3).[Refer to tag 276, 10A NCAC 13F ,0902(c)(4) Personal Care and Supervision (Type A1 Violation).] 6. Based on observation, interviews and record

review, the facility failed to assure the required staffing hours were met on first, second and third

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D980 D980 Continued From page 185 shifts (7:00am-3:00pm, 3:00pm to 11:00pm and 11:00pm-7:00am) based on a census of 69 -72 residents, with 29 of 49 shifts sampled from 06/24/19 through 07/14/19 understaffed. [Refer to tag 219, 10A NCAC 13F .0606 Staffing Chart (Type A2 Violation).] 7. Based on observation, interviews, and record review, the facility failed to provide personal care assistance to 2 of 5 residents (Residents #2 and #5) sampled according to the care plans related to Resident #5's colostomy care and personal care and Resident #2's post-surgical care after a knee replacement, [Refer to tag 0269, 10A NCAC 13F .0901(a) Personal Care (Type A2 Violation)]. The Administrator's failure to assure responsibility for the overall operation of the facility resulted in significant noncompliance with state rules and regulations regarding: -Resident #2 not scheduled for cardiology and pulmonology appointments leading to a readmission to the local hospital for chest pains: Resident #3 missing an endocrinology consult for treatment of uncontrolled diabetes which resulted in an elevated A1C and hospitalization for encephalopathy and a blood glucose of 60mg/dL, and Residents #1 and #8 each missing three scheduled colonoscopy appointments. -Resident #9 who was found unresponsive and CPR was not attempted. -Failure to implement physicians' orders for Resident #1 and Resident #8 for colonoscopy preparation; Resident #3 for blood pressure checks, sliding scale insulin administration and finger stick blood sugar checks resulting in a four-day hospitalization with hypoglycemia and encephalopathy, and Resident #13 not receiving

behaviors

Division of Health Service Regulation

Vistaril resulting in increased irritability with

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ HAL060149 07/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4815 NORTH SHARON AMITY ROAD EAST TOWNE** CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D980 D980 Continued From page 186 -Resident #3 who missed 23 of 53 doses of Gemfibrozil and was administered the incorrect dose of Metoprolol resulting in uncontrolled diabetes and high blood pressure, and Resident #4 who missed 30 of 48 doses of Incruse Ellipta, missed 9 of 9 doses of Spiriva, with no documentation of as needed Albuterol nebulizing treatment or as needed Albuterol hand held breathing treatment administered resulting in a hospitalization for dyspnea. -Resident #5 not receiving showers and appropriate care of her colostomy resulting in a noticeable foul body odor and Resident #2 not receiving proper care after a knee replacement resulting in risk of falls and a blood clot due to non-mobility. -Lack of sufficient staffing of personal care aides for 20 of 46 shifts resulting in resident not receiving the necessary personal care assistance after surgery; a lack of supervision of a resident who demonstrated aggressive, disruptive, and threatening behaviors toward other residents and a resident being found deceased on the bathroom floor after a prolonged period of time without staff's knowledge. Failure of the Administrator to assure responsibility for the overall operation, administration, management and supervision of the facility resulted in serious physical harm and serious neglect of residents and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 07/26/19. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 26. 2019.