STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on September 25, 2019 through September 27, 2019.	{D 000}	Responses to the cited deficiencies do not constitute and admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The Plan of correction is prepared soley as a matter of compliance with state laws.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to assure referral and follow up for 2 of 6 sampled residents related to notifying the physician for blood glucose levels above the parameters set by the physician (Resident #6) and not notifying the physician of refusals of insulin and a delayed mental health referral (Resident #1). The findings are: 1. Review of Resident #6's current FL2 dated 09/12/19 revealed: - Diagnoses included diabetes mellitus. -There was an order for Novolog insulin,100units/ml, (used to control elevated blood glucose levels), administer 23 units three	D 273	10A NCAC 13F .0902(b) Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. All New orders will be reviewed for accuracy by the MCM/ED on a daily routine. Any orders that needs or requires a parameter the PCP will be notified to write parameters for the medication at the time of writing the order. All Med-Techs will be inserviced on The Importance of following orders and all Med-Techs will be revaliadated by the LHPS nurse on skills and the understanding of the orders and Mars. All Med-Techs will be instructd on how often they need to notify PCP for refusals and in some cases the specialist. MCM/RCC will follow up with the PCP on a weekly basis to ensure that they are receiving the notifications and to discuss plan of care for any residents that are in need of change to care. Ed will follow up on this with the MCM/RCC on a weekly routine to ensure compliance of community.	10-28-2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wayne Mayer — TITLE: Executive Director — (X6) DATE: 11/04/2019

Karen Polce Reviewed and Acknowledged November 7, 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 1 times a day before meals. -There was an order to check the fingerstick blood sugar (FSBS) before meals, three times a day. A subsequent physician's order dated 09/11/19 revealed an order to notify Resident #6's Endocrinologist if the blood glucose levels were less than 60 or greater than 450. Observation of Resident #6's September 2019 electronic medication administration record (eMAR) revealed: -There was an entry to check the fingerstick blood sugar (FSBS) before meals and at bedtime. -Special instruction, in bold letters, were PLEASE NOTIFY PATIENT'S ENDOCRINOLOGY OFFICE IF BLOOD SUGAR IS GREATER THAN 450 OR LESS THAN 60. -There was a section on the eMAR screen to enter the FSBS readings. -There was a section on the eMAR screen to document notes regarding the blood sugar parameters. Review of the vital signs entered into the eMAR dated 09/25/19 revealed: -On 09/19/19 at 5:48am, FSBS was documented as 451. -On 09/23/19 at 6:14am, FSBS was documented as 505. -On 09/23/19 at 3:42pm, FSBS was documented as 464. -On 09/23/19 at 8:57pm, FSBS was documented as 540. -On 09/24/19 at 6:25am, FSBS was documented as 515. -On 09/24/19 at 5:55pm, FSBS was documented as "High". -On 09/24/19 at 8:57pm, FSBS was documented	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 2 as 453. Review of the Prodigy glucometer manual, used to check the FSBS for Resident #6, revealed: -The reading of "HIGH" appeared when the result was above the measurement limit. -The measurement limit of the glucometer was higher than 600 mg/dl. -The user should immediately consult their healthcare professional. Telephone interview with a representative from the contracted pharmacy on 09/27/19 at 9:15am revealed: -There was a physician's order for Resident #6, dated 09/11/19, to check the FSBS before meals and at bedtime. -The order included 'Please notify the Endocrinology office if the FSBS was greater than 450 or less than 60', in bold letters. -The pharmacy data entry staff included the parameters and other special instructions into the eMAR, if they were specifically stated in a physician's order. -The facility staff could also enter special instructions. -The special instructions, regarding contacting the physician's office for Resident #6's FSBS parameters, were entered on the eMAR by the pharmacy staff. Interview with the Medication Aide (MA) on 09/25/19 at 11:40am revealed: -She checked Resident #6's FSBS at lunch when she was assigned to administer medications on the 100 Hall. -If the FSBS was less than 60 or greater than 450 she was to notify the physician. -She would fax the physician's office staff and follow up with a telephone call.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 3 -She would document in the electronic progress notes the FSBS, and that she had contacted the physician. -She had not documented a FSBS reading greater then 450 or less than 60 for Resident #6. Interview with a second shift MA on 09/26/19 at 3:15pm revealed: -The MAs were responsible to notify the physician of any parameters that exceeded orders. -The MAs should call or fax the physician's office staff and document in the electronic progress notes. -The documentation should include the FSBS reading and the date and time she contacted the physician's office staff. -She had not documented a FSBS for Resident #6 greater than 450 or less than 60. Telephone interview with a third shift MA on 09/27/19 at 9:10am revealed: -She checked Resident #6's blood sugar in the morning before breakfast. -She did not remember any blood sugar parameters or special instructions on the eMAR for Resident #6, alerting her to contact the Endocrinologist if the FSBS was greater than 450 or less than 60. -The MA did not notify the physician or the facility nursing staff on 09/23/19 at 8:57pm when Resident #6's FSBS was 540. -The MA did not notify the physician or the nursing staff on 09/24/19 at 6:25am when Resident #6's FSBS was 515. -She would normally be concerned with an elevated blood sugar reading, but she did not see any parameters on Resident #6's FSBS order. -She probably should have contacted the physician's office, but the mornings were very busy and it escaped her.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 4 Attempted telephone interview with another MA on 09/27/19 at 9:06am was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 09/26/19 at 12:35pm revealed: -The MAs were primarily responsible for notifying the physician when a resident's FSBS parameters had been exceeded. -If the Director of Resident Care (DRC) or the RCC were informed by the MA the blood sugar reading was above the ordered parameters, they would notify the physician. -The RCC would use the Physician Visit Documentation form and fax the FSBS to the physician's office, notifying the office staff the FSBS was above the parameters set by the physician. -She would follow up with a phone call and document in the electronic progress notes. -She had not been notified by the MAs that Resident #6's FSBS was above 450. -It was all of their responsibilities to notify the physician if a residents blood sugar, or any vitals, go above the parameters ordered by the physician. Interview with the Administrator on 09/26/19 at 3:40pm revealed: -Resident #6's eMAR entry, since 09/12/19, included the instructions to contact the physician's office if the parameters were greater than 450 and less than 60. -It was the responsibility of the MA to contact the physician's office by fax or phone, document the day and time of the contact, and if there were additional physician orders. -If contact with the physician's office had not been documented, then the MAs had not followed the process for following up with the physician as	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 5 ordered. -The DRC should check the eMARs daily through the Point of Compliance report. -The DRC supervised the MAs and was responsible for ensuring orders were carried out as written by the physicians. Interview with Resident #6's primary care provider (PCP) on 09/26/19 at 4:05pm revealed: -She was the primary care physician for Resident #6. -She was concerned regarding Resident #6's continued elevated blood sugars. -She referred Resident #6 to an Endocrinologist in August of 2019 to manage her diabetes. -The PCP questioned the communication between the staff and the Endocrinologist, since there had been no medication changes since the August visit, and the blood sugar continued to be elevated. -These high blood sugars could cause diabetic ketoacidosis, (a potentially life threatening problem that occurs when the body starts breaking down fat for energy, which causes the blood to become too acidic), and possible organ failure. Attempted interview with the DRC on 09/26/19 at 4:10pm was unsuccessful. Attempted telephone interviews with Resident #6's Endocrinologist on 09/26/19 at 4:10pm and 09/27/19 at 11:20am were unsuccessful Based on observations and interviews it was determined Resident #6 was not interviewable. 2. Review of Resident #1's current FL2 dated 09/12/19 revealed diagnoses included dementia, diabetes mellitus type 2, hypertension, and	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 6 hyperlipidemia. Review of Resident #1's Resident Register revealed she was admitted to the facility on 06/26/19. a. Review of Resident #1's hospital discharge summary dated 06/26/19 with indicated "patient would benefit from outpatient psychiatric services for a longitudinal assessment of symptoms and consideration of possible psychotropics". Review of a consultation note from the primary care provider (PCP) dated 07/03/19 revealed "a formal evaluation by the in-house psych [sic] provider was recommended, discussed with the ED [sic] and MCC [sic] to arrange, no other changes at this time. " Review of a consultation note from the PCP dated 07/31/19 revealed there was documentation of treatment for mild cognitive impairment, "patient is to be seen by facility psych [sic] provider for further evaluation". Review of a note written to the physician dated 08/06/19 revealed the resident had been more agitated, the note did not indicate which staff member wrote the note. Review of a consultation note from the PCP dated 08/21/19 revealed there was documentation the resident had some paranoia, "awaiting psych eval [sic]". Review of Resident #1's record revealed: -There was a consent signed for psychological services on 08/19/19. -There were no mental health progress notes available for review.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 7 Review of Resident #1's progress notes revealed: -On 08/17/19 at 9:28am, a medication aide (MA) documented "resident refused all medication and insulin this morning stating that we knew better than to give her anything, she was not taking anything from us". -On 08/21/19 at 1:10pm, a MA documented "resident still refuses insulin and medication and thinks the building is out to get her and we are going to kill her, resident exhibited paranoid behavior with the doctor in the room". -On 08/21/19 at 9:54am, a MA documented "resident refused blood sugar check and all medication this morning stating that we are giving her things to make her sick and she doesn't need to be here, she had the government on her side". -On 08/22/19 at 9:18am, a MA documented "resident claimed that her breakfast was poisoned so she did not eat it". On 09/04/19 at 9:41am, a MA documented "resident was extremely rude, swearing, and wondering what kind of place was in". -On 09/23/19 at 10:49am, the Director of Resident Care (DRC) documented the resident was seen by the in-house psychosocial provider and there were no changes. Telephone interview with the contracted mental health provider on 09/26/19 at 11:46am revealed: -He was the contracted mental health provider for the facility. -There was no other mental health provider that came to the facility from his agency. -He had not evaluated Resident #1, "she is not my patient". Interview with Resident #1's legal guardian on 09/27/19 revealed: -The resident had a history of schizophrenia and	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 8 bipolar disorder. -Resident #1 saw the mental health provider, "but it was not timely". -She requested the resident see a mental health provider on 08/16/19 due to history of psychological issues. -She faxed a consent to the facility on 08/16/19 and 08/21/19. -She called the DRC on 08/19/19 to confirm the receipt of fax and there was no response. -She asked that the facility notify her of the date of the initial visit so that she could give the mental health provider a history on the patient. -The mental health provider came to the facility and completed the evaluation without speaking with her and getting the mental health history. -In August, she noticed the resident was more confused than usual and had increased hallucinations. -She told the Administrator of the breakdown in communication and it was not addressed. -The resident was eventually seen by the in-house mental health provider on 09/09/19, "The provider called me, I don't know why he would say that he did not see her". Interview with the Resident Care Coordinator (RCC) on 09/27/19 at 9:32am revealed: -She thought the resident saw the mental health provider, however she was unable to find the mental health progress notes. -She remembered talking to the guardian about getting the mental health consent processed. -The DRC was responsible for completing the referral process and ensuring that the resident was seen by the mental health provider. -She assisted the DRC with what she instructs her to do and she was not instructed to follow-up with Resident #1's mental health evaluation. -"I am not sure what happened."	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 9 Interview with the primary care provider (PCP) on 09/26/19 at 4:23pm revealed: -Initially, the resident did not present with paranoia, however when she completed a mini psychological exam the resident scored low and she ordered a psychological evaluation on 07/03/19. -She ordered the resident to see the contracted mental health provider on 08/21/19 but she was not seen, she was told Resident #1 was scheduled but the appointment was cancelled. -The resident displayed symptoms of paranoia and talked about the staff trying to kill her. -She spoke to the previous RCC on 07/03/19 about the mental health evaluation and it was scheduled 3 weeks out. -She would expect the staff to let her know the resident had not been seen by the mental health provider. -She could have arranged for a mental health provider from her practice see the resident. -If Resident #1 were to see the mental health provider sooner, it could have helped treatment for paranoia, hallucinations, and possibly helped resident refuse medications less often. Interview with the Administrator on 09/27/19 at 10:20am revealed: -She expected the DRC to ensure that referrals were processed timely. -She expected residents to be seen by the provider of the resident/guardian choice at the next available visit. -She did not know Resident #1 was not seen by the mental health provider. -She was told on 09/25/19 by the legal guardian that the resident was being discharged on 09/25/19 due to lack of communication with staff. -There should have been follow-up with the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 10 mental health referral/evaluation by the DRC or RCC. b. There was a previous physician's orders signed 07/24/19 revealed there was an order for Humalog (used to control high blood sugars) 100u/mL 10 units 15 minutes before or immediately after meals three times daily. Review of a Resident #1's record revealed there was an order dated 08/21/19 to discontinue Humalog insulin 10 units three times daily 15 minutes before meals or immediately after a meal. Review of Resident #1's electronic medication administration record (eMAR) for August 2019 revealed: -There was an entry for Humalog 100u/mL to be administered three times daily 15 minutes before meals or immediately after a meal. -There was documentation Humalog 100u/mL was refused 23 out of 68 opportunities from 08/01/19-08/23/19. -The residents blood sugars ranged from 78-376. Review of Resident #1's hospital discharge summary dated 06/26/19 revealed, the resident's A1C (test used to measure the average blood glucose, normal range is 4-5.7) was 9.5. Review of Resident #1's progess notes revealed: -There was a progress noted indicating the primary care provider (PCP) was notified of the resident refusing Humalog on 08/06/19. -The PCP was notified of the resident refusing Humalog on 08/21/19. -There was no other documentation the physician had been notified of refusals of Humalog insulin.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 11 Interview with a medication aide (MA) on 09/26/19 at 12:20pm revealed: -She did not remember if Resident #1 refused insulin when she worked. -She would contact the doctor immediately if residents refused insulin and would document in the progress notes. -MAs were to get another MA to try and administer a medication if a resident was refusing, and notify the Resident Care Coordinator (RCC), Director of Resident Care (DRC) and the physician. -The MAs were to call the physician and fax correspondence to notify of each insulin refusal. Interview with a MA on 09/26/19 at 4:20pm revealed: -If a resident refused a medication, she was to get another MA to attempt to administer the medication. -If the resident continued to refuse, she was to notify the physician after 3 refusals. -If a resident refused a medication such as insulin the physician was notified immediately after first refusal. -She was also to notify the RCC and DRC of any refusals and document in the progress notes, after each refusal. -She could not remember if she called the physician when Resident #1 refused her Humalog, "I may have gotten busy". -She notified the RCC a couple of times about Resident #1's Humalog refusals. -The previous RCC and Administrator instructed that the physician was to be called after each refusal of insulin. -Resident #1 presented with paranoid behavior and did not always trust staff with medication administration.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 12 Interview with the primary care provider (PCP) on 09/25/19 at 4:09pm revealed: -The facility left a few refusal notes for Resident #1. -She expected to be notified each time a resident refused insulin. -She was not notified that the resident missed 23 out of 68 doses of Humalog. -She discontinued Humalog because she was notified that the resident refused a few times. -She did not have access to the eMARs during each visit to know how many times a resident was refusing medications. -If staff did not call or fax her of refusals, then she was not aware. -Resident #1 refusing 23 out of 68 doses would cause the resident to be at risk for hyperglycemia, internal organ damage, and hospitalization. -She would like to be notified so that she could check her blood sugars or adjust other insulin medications sooner. Interview with the RCC on 09/27/19 at 9:32am revealed: -She did not know Resident #1 missed 23 out of 68 doses of Humalog. -She knew the resident did not trust staff and constantly asked why medications were given but did not know she missed so many doses of Humalog. -After the first refusal of insulin she expected the staff to call or fax the physician. -She was not sure if there was a written policy for refusals. -She expected the staff to also notify her or the DRC if the resident refused insulin. Interview with Resident #1's legal guardian on 09/27/19 at 9:34am revealed: -Resident #1 had a history of schizophrenia and	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 13 bipolar disorder. -Resident #1 had a history of not taking medications as ordered and it was part of the reason she was admitted to a facility. -She did not know of any refusals of medications. Interview with the Administrator on 09/27/19 at 10:20am revealed: -MAs were to follow the "state policy" and after 3 refusals notify the PCP. -If a resident was to refuse insulin, she expected the PCP to be notified immediately. -There was no written policy for medication refusals. -The DRC and RCC was responsible for reinforcing the rules and ensuring that staff was notifying the PCP of refusals. The failure of the facility to notify the physician resulted in Resident #6 being a significant risk for diabetic ketoacidosis and hospitalization, and Resident #1, with a history of non compliance due to a history of schizophrenia and bipolar disorder, with a delayed mental health referral for two months, despite an increase in paranoia behaviors, resulted in increased medication non-compliance which included a fast acting insulin, which put Resident #1 at risk for hyperglycemia and hospitalization. This failure resulted in substantial risk for physical harm for Resident #6 and Resident #1 and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/26/19. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 27, 2019.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 14	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure orders for fingerstick blood sugar (FSBS) checks were completed as ordered for 1 of 5 sampled residents (#6). Review of Resident #6's current FL2 dated 09/12/19 revealed there was an order for fingerstick blood sugar (FSBS) checks three times daily before meals. A previous physician's order dated 09/11/19 revealed an order to notify Resident #6's Endocrinologist if the blood glucose levels were less than 60 or greater than 450. Observation of Resident #6's September 2019 electronic medication administration record (eMAR) revealed:	D 276	10 A NCAC 13F .0902 (c)(3-4) Health Care (c) the facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physicaian or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. All new orders will be reviewed for accuracy by the MCM/ED on a daily routine. Any order that is written or will be proccessed by the "Order Processing System" and then placed in a too be filed folder. Filing will be done weekly at the minium to ensure that all records are up to date. All notes from doctors visits will be placed in the chart as they are received and reviewed to ensure that all orders, appointments will be handled in the approriate time frame. ED will follow up with the MCM/RCC to ensure that the filing and documentation is placed in the charts at minium once per week. ED will also assist with the filing of any orders and or documentation once reviewed to ensure that community stays in compliance and that records are up to date. MCM/RCC will instruct staff on the new system and how it will be processed in case of an emergency or after hours admission to ensure that all orders have been processed in a adequate time frame.	Oct. 28, 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 15 -There was an entry to check the fingerstick blood sugar (FSBS) before meals at 6:30am, 12:00pm and 4:30pm. -Special instruction, in bold letters, were PLEASE NOTIFY PATIENT'S ENDOCRINOLOGY OFFICE IF BLOOD SUGAR IS GREATER THAN 450 OR LESS THAN 60. -There was no documentation FSBS was checked at 12:00pm on 09/20/19 or 09/25/19. -There was no progress note indicating a reason for the exception. -There were 2 of a possible 24 opportunities at 12:00pm the FSBS was not documented as checked. -There was no documentation the FSBS was checked at 4:30pm from 09/12/19 through 09/15/19 and 09/17/19 through 09/25/19. -There were 13 of a possible 24 opportunities at 4:30pm the FSBS was not documented as checked. -There was no progress note indicating a reason for the exception. Interview with a medication aide (MA) on 09/26/19 at 3:15pm revealed: -If a resident had an order to check the FSBS, it would populate on the eMAR at the scheduled time. -There would be a drop down box to enter the results of the FSBS. -When she checked the FSBS she would sign off on the completion of the tasks. -If there was no drop down box to enter the FSBS result, she would not check the FSBS. -She was one of the MAs who administered Resident #6's medications from 09/12/19 through 09/25/19. -If the FSBS results were not documented on the eMAR, she did not check the FSBS.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 16 Review of the vital signs entered into the eMAR dated 09/25/19 revealed: -On 09/19/19 at 5:48am, FSBS was documented as 451. -On 09/23/19 at 6:14am, FSBS was documented as 505. -On 09/23/19 at 3:42pm, FSBS was documented as 464. -On 09/23/19 at 8:57pm, FSBS was documented as 540. -On 09/24/19 at 6:25am, FSBS was documented as 515. -On 09/24/19 at 5:55pm, FSBS was documented as "High". -On 09/24/19 at 8:57pm, FSBS was documented as 453. Review of the Prodigy glucometer manual, used to check the FSBS for Resident #6, revealed: -The reading of "HIGH" appeared when the result was above the measurement limit. -The measurement limit of the glucometer was higher than 600 mg/dl. -The user should immediately consult their healthcare professional. Interview with the Administrator on 09/27/19 at 9:00am revealed: -The facility's contracted pharmacy staff entered all medication orders into the eMAR. -The Director of Resident Care (DRC) was then responsible for verifying the orders were entered correctly. -In verifying the FSBS orders, the DRC had to verify the times of administration were correct and the drop down boxes were activated, to allow the MAs to enter the data. -If the MAs had checked the FSBS, but did not have a place to document the results on the eMAR, they should have documented the results	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 17 in the progress notes. -If the MAs did not document in the progress notes, it meant they did not check the FSBS. Interview with the Resident Care Coordinator (RCC) on 09/27/19 at 9:59am revealed: -She was the RCC and a MA. -If a resident had an order to check FSBS, it would "pop" up and highlight in blue on the eMAR when it was time to check their FSBS. -There would be a space to enter the results of the blood sugar check. -She had not been told that any orders were not highlighted on the eMAR screen prompting administration at their allotted time.	D 276		
{D 352}	10A NCAC 13F .1003(a) Medication Labels 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed; (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date; (8) auxiliary statements as required of the medication; (9) the name, address, telephone number of the dispensing pharmacy; and	{D 352}	10A NCAC 13F .1003 (a) Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance;(3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and precription serial number;(5) directions for use stated and not abbreviated;(6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed;(7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date; (8) auxiliary statements as required of the medication; (9) the name, address, telephone number of the dispensing pharmacy; and (10) the name or intials of the dispensing pharmacist. Medications will be checked for accuracy of the labels to ensure that correct medications are secured with a correct label to ensure accuracy of the medications to be given. Any medication that is found to have a incorrect label will be given a change order sticker if applicable and a new medication will be ordered for any medication that cannot receive a change order sticker. Med-Techs will be in-serviced on the proper use of a change order sticker and will be instucted on when to use this sticker. All medications will be marked with a expiration date and a open date where this is applicable. This process will be reviewed weekly by the MCM/RCC for accuracy of medications by auditing of carts. ED will do audits of the carts at least monthly to ensure that processes are being followed.	Nov. 8 , 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 352}	Continued From page 18 (10) the name or initials of the dispensing pharmacist. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure medications were properly labeled for 3 of 7 sampled residents (Resident #2, #3 and #8), as related to two vials of short acting insulin (Residents #2 and #8) and one vial of long acting insulin (Resident #3). The findings are: 1. Review of Resident #2's current FL2 dated 09/12/19 revealed: -Diagnoses included diabetes mellitus. -There was an order for Humalog insulin 100units/ml, (used to treat elevated blood glucose levels), per sliding scale parameters, before meals and at bedtime. -The sliding scale parameters were as follows: 151-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; 401-450=12 units; 451-500=14 units. -There was an order for fingerstick blood sugars (FSBS) to be checked 4 times a day, before meals and at bedtime. -If the blood sugar was less than 60 or greater than 500, the staff were to call the prescribing physician. Observation of Resident #2's medications on hand for administration on 09/25/19 at11:45am revealed: -The Humalog insulin vial was in a plastic bag with a pharmacy generated label. -The label had Resident #2's name, the name of the insulin (Humalog 100units/ml) and 'inject per	{D 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 352}	Continued From page 19 sliding scale before meals and at bedtime as follows'. -The Humalog insulin was dispensed on 08/16/19. -There was a handwritten opened date of 09/10/19 on the side of the plastic bag. -There were no directions as to the sliding scale parameters on the computer-generated label. -There were no directions for the sliding scale parameters on the insulin vial inside the plastic bag. Interview with the first shift medication aide (MA) on 09/26/19 at 3:15pm revealed: -She administered Resident #2's Humalog sliding scale insulin when needed. -She did not realize the sliding scale parameters were not on the pharmacy generated label affixed to the bag. -She usually checked both the medication label and the electronic medication administration record (eMAR) before administering medication to the residents. -She knew Humalog 100units/ml was the correct insulin for Resident #2 according to the sliding scale order entry on the eMAR. -She followed the eMAR entries for the sliding scale parameters. -Medications should have labels with directions for their administration and correspond with the order entry on the eMARs. -She should have brought this to the attention of the Director of Resident Care (DRC) to contact the pharmacy to provide a label with directions for administration of the Humalog insulin for Resident #2. Attempted interview with the DRC on 09/26/19 at 4:10pm was unsuccessful.	{D 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 352}	Continued From page 20 2. Review of Resident #8's current FL2 dated 09/12/19 revealed: - Diagnoses included diabetes mellitus. -There was an order for Novolog insulin 100units/ml, (used to control elevated blood glucose levels), administer three times a day before meals per sliding scale parameters. -The sliding scale parameters were as follows: 300-350=2 units; 351-400=4 units; 401-450=6 units; 451-500=8 units; blood sugar greater than 500=10 units. Observation of Resident #8's medications on hand for administration on 09/25/19 at 11:55am revealed: -The Novolog insulin vial was in a cardboard container with a pharmacy generated label. -The label had Resident #8's name, the name of the insulin (Novolog 100units/ml) and 'see enclosed directions'. -There were no enclosed directions. -The Novolog insulin was dispensed on 07/16/19. -There was a handwritten opened date of 09/23/19 on the side of the cardboard container. -There were no directions on Resident #8's computer-generated label, as regards the administration of the insulin. -There were no directions for the administration of Resident #8's Novolog on the insulin vial inside the cardboard container. Interview with the first shift medication aide (MA) on 09/26/19 at 3:25pm revealed: -She administered Resident #8's Novolog sliding scale insulin when needed. -She knew the sliding scale parameters were not on the pharmacy generated label on the box or the insulin vial. -She referred to the electronic medication administration record (eMAR) before	{D 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 352}	Continued From page 21 administering medication to the residents. -She knew the Novolog 100units/ml was the correct insulin for Resident #8 according to the sliding scale order entry on the eMAR. -She followed the eMAR for the sliding scale parameters. -Medications should have labels with directions for their administration and correspond with the order entry on the eMARs. -She should have brought this to the attention of the Director of Resident Care (DRC) to contact the pharmacy to provide a label with directions for administration of the Novolog insulin for Resident #8. Interview with Administrator on 09/26/19 at 3:50pm revealed: -The MAs should be checking the label to verify it matched the order. -If there was a discrepancy, the MAs should not put the medication on the cart. -When the MAs are doing cart audits, they should also be comparing the label to the physician order summary and the eMARs. -They should notify the DRC or the Resident Care Coordinator (RCC) if the label was incorrect or missing from the medication. -The DRC should follow up behind the MAs to assure medications were labeled properly. -It was the MAs responsibility to verify the accuracy of the labels with the order entries as part of their check system when administering medications. Interview with the Resident Care Coordinator (RCC) on 09/26/19 at 4:45pm revealed: -She was the interim RCC and assisted the DRC as needed. -The DRC was responsible for assuring medications were administered as ordered,	{D 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 352}	Continued From page 22 including medications properly labeled, and she assisted as directed by the DRC. -Checking the label on the medications was part of the cart audit process. -In between cart audits, any MA who administered medications was responsible to verify the medication labels with the order entries on the eMARs, as part of a correct medication administration process. -She did not know some of the insulin vials and packaging did not have the orders for administration of the insulin. -She relied on the MAs to inform her if there was incorrect labeling of medications. 3. Review of Resident #3's current FL2 dated 09/12/19 revealed: -Diagnoses included Alzheimer's dementia, hypertension, hyperlipidemia and chronic pancreatitis. -There was a medication order for Levemir (an insulin to treat diabetes) inject 50 units at bedtime. Review of Resident #3's physician orders dated 07/23/19 revealed a medication order for Levemir inject 30 units at bedtime. Review of Resident #3's physician orders dated 08/13/19 revealed a medication order for Levemir inject 36 units at bedtime. Review of Resident #3's physician orders dated 09/03/19 revealed a medication order for Levemir inject 50 units at bedtime. Observation of Resident #3's medications available for administration on 09/26/19 at 11:47am revealed:	{D 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 352}	Continued From page 23 -There was an opened bottle of Levemir with a computer generated label affixed to the bottle with directions to inject 36 units at bedtime. -There was a sticker affixed to the bottle of Levemir 36 units indicating the bottle was opened on 09/18/19. -There was an opened bottle of Levemir with a computer generated label affixed to the bottle with directions to inject 50 units at bedtime. -There was a sticker affixed to the bottle of Levemir 50 units indicating the bottle was opened on 09/04/19. Interview with a medication aide (MA) on 09/26/19 at 11:47am revealed: -She referred to the directions on Resident #3's eMAR to administer his Levemir. -Resident #3's current order for Levemir was inject 50 units at bedtime. -Even though the directions on one of Resident #3's Levemir bottles had directions to administer 36 units, she administered 50 units. -She did not know why Resident #3 had two opened bottles of Levemir, with different directions, available for administration. Interview with a second MA on 09/26/19 at 3:57pm revealed: -When administering medications, she compared the order on the eMAR to the directions on the medication prior to administration. -If an order was received for a change in dose of a medication, the MAs were responsible for affixing a sticker to the label to alert the MAs the dose had changed and to refer to the dose on the eMAR. -Prior to adding the sticker to the medication, she would verify the correct dose with either the Director of Resident Care (DRC) or the Resident Care Coordinator (RCC).	{D 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 352}	Continued From page 24 -She had administered Levemir 50 units to Resident #3 after the Levemir bottle containing directions for injecting 36 units was opened (09/18/19), but she did not realize the label on the bottle did not match the order on the eMAR so she did not place an "order change" sticker on the bottle or alert the RCC or DRC. Interview with a third MA on 09/27/19 at 8:52am revealed: -She administered medications based on the order entry on the eMAR. -If the directions on the medication label was different from the entry on the eMAR, MAs were responsible for notifying the DRC, or the RCC, in the absence of the DRC. -The DRC would either make changes to the medication label herself or would ask the MA to do it. -If the MA was asked to make changes to the medication label, she would either handwrite the changes directly onto the pharmacy label or affix a sticky note to the medication with the new order handwritten on the sticky note. -The facility did not have "order change" stickers to affix to the label. Interview with the RCC on 09/27/19 at 9:38am revealed: -If a dose was different on a medication label verses what was on the eMAR, the MAs should administer medications based on the dose reflected on the eMAR. -If MAs found a discrepancy between the medication label and the eMAR, they should notify her so she could verify the order and place an "order change" sticker on the medication label. -No one had notified her Resident #3 had a bottle of Levemir with directions to inject 36 units. -The MAs could use up the Levemir in the bottle	{D 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 352}	Continued From page 25 with directions to inject 36 units but the bottle would need to have an "order change" sticker applied to it. -The facility currently did not have any "order change" stickers, but she had ordered more from the pharmacy on 09/26/19. Interview with the Administrator on 09/27/19 at 9:00am revealed: -MAs should compare the label on the medication to the eMAR prior to administering any medication. -If a MA found a medication label that did not match the entry on the eMAR, they should notify either the DRC or herself so the order could be verified, and an "order change" sticker could be placed on the medication immediately. -She knew medication cart audits had been completed on 09/11/19 and 09/17/19. -Medication cart audits should be completed by Thursday of each week by the MAs, but she did not know if an audit had been completed since 09/18/19 when the bottle of Levemir 36 units had been opened for Resident #3. -Medication cart audits should assist MAs in finding medications containing labels that did not match the eMAR. -She did not know why no one had added an "order change" sticker to Resident #3's Levemir bottle.	{D 352}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:	{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practionioner which are maintained in the resident's record and (2) rules in this Section and the facilities policies and procedures.	Oct. 25, 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 26 (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that serious physical harm will occur. TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 6 residents observed during the medication pass (Residents #6 and #7), including a scheduled fast acting insulin dosage not administered before lunch (Resident #6) and a scheduled mood stabilizer not administered as ordered (Resident #7), and for 3 of 5 residents sampled for review (Residents #1, #3 and #5) including errors with a fast acting insulin and oral medication used to treat Type 2 diabetes (Resident #3), failure to administer antipsychotic medication as ordered (Resident #1), and failure to have a medication ordered for nausea available for administration (Resident #5).	{D 358}	Monthly medication cart audits will be performed by community RCC/MCM, along with the continued weekly audits performed by communities medication aide staff. Community Administrator will review both weekly and monthly medication audits. Community Administrator will receive both weekly and monthly medication cart audits once monthly to assure compliance. Cycle fill audits completed by the Medication Aides and the oversight of the MCM prior to the new start of the cycle with the ED and Divisional Nurse oversight as needed and ongoing. All orders will be reviewed by the MCM/RCC with assist from the ED and any orders that need clarifications will be addressed with the PCP immediately. Any order that requires a parameter will be reviewed by the MCM/RCC. The PCP will be notified of any outside range with instructions/recommendations to follow. Med-Techs will be inserviced on the Importance of Parameters and how and when to notify the PCP. The in-service will be conducted by the LHPS Nurse with oversight by both the ED and the Divisional Nurse for on going compliance. All residents will be recommended too use Omnicare as their back-up Pharmacy in the case of not being able to get Meds from their pharmacy in a timely manner. All residents who do not use Omnicare for their primary needs will be placed on a tracking tool so the Med-Techs and MCM/RCC know when to order. This will be reviewed by the ED on a monthly routine to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 27 The findings are: The medication error rate was 7% as evidenced by the observation of 2 errors out of 29 opportunities during the 11:30am medication pass on 09/25/19 and the 8:30am medication pass on 09/26/19. 1. Review of Resident #6's current FL2 dated 09/12/19 revealed diagnoses included diabetes mellitus. a. Review of Resident #6's current FL2 dated 09/12/19 revealed there was an order for Novolog 100units/ml, a fast acting insulin used to control elevated blood glucose levels, administer 23 units three times a day before meals. Observation of the medication pass on 09/25/19 at 11:30am revealed: -The medication aide (MA) checked Resident #6's fingerstick blood sugar (FSBS), observing infection control protocol. -The FSBS was 428. -Resident #6 also was administered another medication tablet with a 5 ounce cup of water. -The portion of the computer screen visible highlighted the FSBS check and a medication tablet to be administered. -The MA stated there were no other medications or procedures to be administered at this time. Interview with the MA on 09/25/19 at 11:40am revealed: -She did not have any insulin medication scheduled to be administered to the residents on the 100 Hall. -Resident #6 was not ordered any insulin before lunch.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 28 -She only had to check the FSBS at lunch and notify the physician if the reading was greater than 450. Review of Resident #6's record revealed there was no order to discontinue Novolog insulin, 23 units to be administered three times a day before meals, since the current FL2 dated 09/12/19. Observation of Resident #6's medications on hand to be administered, on 09/26/19 at 3:40pm, revealed: -There was a vial of Novolog insulin 100 units/ml with a computer generated pharmacy label attached to the vial. -The label had Resident #6's name, the name of the insulin and the directions: 23 units to be administered before meals three times a day. -The Novolog insulin was dispensed on 08/29/19. Second interview with the MA on 09/25/19 at 12:45pm revealed: -She did not know Resident #6 was to be administered insulin before lunch. -She did not see the order highlighted on the eMAR. -If an order did not "pop" on the eMAR to identify a medication to be administered, she had no way of knowing the resident had a medication due at that time. -She did not know why the medication was not highlighted on the eMAR screen to administer. -The MA was directed by the Administrator to administer the Novolog insulin 23 units to Resident #6 immediately. Interview with another MA on 09/25/19 at 3:15pm revealed: -She thought Resident #6 had scheduled insulin before meals but was not sure.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 29 -She never had the experience of a medication not being highlighted on the eMAR at the time of administration. Review of Resident #6's electronic medication administration record (eMAR) for September 2019 revealed: -There was an entry for Novolog insulin 100units to be administered three times a day, scheduled for 6:30am, 12:00pm and 4:30pm. -There was no documentation Novolog 23 units was administered at 12:00pm on 09/20/19 or 09/25/19. -There was no progress note indicating an exception for administration of Novolog insulin on 09/20/19 or 09/25/19 at 12:00pm. -There were 2 of a possible 24 opportunities at 12:00pm that Novolog insulin was not documented as administered. -There was no documentation Novolog 23 units was administered at 4:30pm from 09/12/19 through 09/15/19 and 09/17/19 through 09/25/19. -There were 13 of a possible 24 opportunities at 4:30pm Novolog insulin was not documented as administered. -There was no progress note indicating an exception for administration of Novolog insulin from 09/12/19 through 09/15/19 and 09/17/19 through 09/25/19. Review of the vital signs entered into the eMAR dated 09/25/19 revealed: -On 09/19/19 at 5:48am, FSBS was documented as 451. -On 09/23/19 at 6:14am, FSBS was documented as 505. -On 09/23/19 at 3:42pm, FSBS was documented as 464. -On 09/23/19 at 8:57pm, FSBS was documented as 540.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 30 -On 09/24/19 at 6:25am, FSBS was documented as 515. -On 09/24/19 at 5:55pm, FSBS was documented as "High". -On 09/24/19 at 8:57pm, FSBS was documented as 453. Review of the Prodigy glucometer manual, used to check the FSBS for Resident #6, revealed: - The reading of "HIGH" appeared when the result was above the measurement limit. -The measurement limit of the glucometer was higher than 600 mg/dl. -If the glucometer reads "HIGH", the user should immediately consult their healthcare professional. Interview with a medication aide (MA) on 09/26/19 at 3:15pm revealed: -If a resident had an order for insulin, it would populate on the eMAR when it was time to administer their insulin. -There would be a drop down box to enter the units of insulin administered. -When she administered the insulin, she would sign off on the completion of the task. -If there was no drop down box to enter the units of insulin administered, she would not administer the insulin. -She was one of the MAs who administered Resident #6's medications from 09/12/19 through 09/25/19. -If the insulin units administered were not documented on the eMAR, she did not administer the insulin. Attempted telephone interview with another MA on 09/27/19 at 9:08am was unsuccessful. Interview with the Administrator on 09/27/19 at 9:00am revealed:	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 31 -The facility's contracted pharmacy staff entered all medication orders into the eMAR. -The Director of Resident Care (DRC) was then responsible for verifying the orders were entered correctly. -In verifying the insulin orders, the DRC had to verify the times of administration were correct and the drop down boxes were activated to allow the MAs to enter the data. -The DRC should check the eMARs daily through the report generated by the eMAR program. -This report showed medications not administered, duplicate orders and medications administered late. -If the MAs had administered the insulin but did not have a place to document the results on the eMAR, they should have documented the results in the progress notes. -If the MAs did not document in the progress notes, they did not administer the insulin. Interview with the Resident Care Coordinator (RCC) on 09/27/19 at 9:59am revealed: -She was the RCC and a MA. -If a resident had an order for insulin, it would "pop" up and highlight in blue on the eMAR when it was time to administer their insulin. -There would be a space to enter the site of the administration and the amount of insulin administered. -She had not been told that any medications were not highlighted on the eMAR screen at their allotted time. Interview with Resident #6's primary care provider (PCP) on 09/26/19 at 4:05pm revealed: -She was the primary care physician for Resident #6. -She was concerned regarding Resident #6's continued elevated blood sugars.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 32 -She referred Resident #6 to an Endocrinologist in August of 2019 to manage her diabetes. -The PCP questioned the communication between the staff and the Endocrinologist, since there had been no medication changes since the August visit, and the blood sugar continued to be elevated. -These high blood sugars could cause diabetic ketoacidosis, (a potentially life threatening problem that occurs when the body starts breaking down fat for energy, which causes the blood to become too acidic), and possible organ failure. Attempted telephone interview with the Endocrinologist on 09/26/19 at 4:10pm and 09/27/19 at 11:20am was unsuccessful. Attempted interview with the DRC on 09/26/19 at 4:10pm was unsuccessful. Based on observations and interviews it was determined Resident #6 was not interviewable. 2. Review of Resident #7's current FL2 dated 09/12/19 revealed: - Diagnoses included Alzheimer dementia with behavioral disturbances, anoxic brain damage, convulsions and legal blindness. -There was an order for Paroxetine HCL 40mg, administer one half tablet daily for mood stability. Observation of the medication pass on 09/26/19 at 8:30am revealed: -There was a medication bottle with a pharmacy generated label and Resident #7's name. -The directions on the label read Paroxetine 40 mg one half tablet (20mg) daily for mood stability. -The prescription was dispensed on 09/17/19 for 12 tablets.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 33 -The medication aide (MA) removed one whole tablet, 40mg, and could not find a pill splitter on the cart. -The MA informed the Administrator there were no pill splitters on either medication cart in the facility. -The Administrator sent a staff person to purchase a pill splitter locally. -In the interim, a staff person found a plastic pill splitter in the medication room which was cleaned and able to be used. -The MA split the tablet and administered to Resident #7 with water. Observation of Resident #7's medications on hand available for administration on 09/26/19 at 8:45am revealed: -There was a bottle of Paroxetine with 12 whole tablets. -The fill date on the pharmacy bottle was 09/17/19. -12 tablets were sent on 09/17/19, with directions to administer one half tablet (20mg) daily. Review of Resident #7's electronic medication administration record (eMAR) for September 2019 revealed: -There was an entry for Paroxetine 40 mg, one half tablet 20mg daily, for mood stability. -There was documentation Paroxetine was administered on 09/18/19 at 8:00am, and 09/20/19 through 09/26/19 at 8:00am. -There was documentation Paroxetine was not administered on 09/17/19 at 8:00am and 09/18/19 at 8:00am due to the medication not in the facility. -Based on MAR review and observation of medications on hand, there should have been seven and one half tablets left if the Paroxetine had been administered as ordered.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 34 Interview with a MA on 09/27/19 at 11:30am revealed: -She had administered Resident #7's medications on 09/17/19. -She had documented on the electronic progress notes "Not administered - RX order." -RX order was the documentation entered when a medication was not in the building and the staff were awaiting its arrival. -On 09/19/19, the MA was again administering Resident #7's medications and documented on the eMAR progress note 'Not administered-RX order'. -The MA informed the DRC and the RCC Resident #7's Paroxetine was not in the facility to be administered. -The MA faxed a notification to Resident #7's pharmacy and called leaving a message regarding the medication not available for administration. -She had been off the past few days and found the medication on the cart this morning. Interview with the responsible family member on 09/27/19 at 10:20am revealed: -Resident #7's medications were all ordered through Resident #7's pharmacy. -She brought Resident #7's medications to the facility for administration by the staff. -She brought the Paroxetine tablets on Sunday, 09/22/19. -There were 12 whole tablets in the medication bottle. Interview with the MA on 09/26/19 at 3:15pm revealed: -She did not remember documenting the administration of Paroxetine to Resident #7 on 09/18/19, 09/21/19 and 09/22/19.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 35 -She was very careful in administering medications and only documented what she had administered. -She could not explain why she had documented Paroxetine was administered to Resident #7 when there was documentation the medication was not in the building. Interview with the primary care physician (PCP) on 09/27/19 at 9:30am revealed: -She was not the physician who prescribed Paroxetine to Resident #7. -Paroxetine was an antidepressant which assisted with mood stability. -Resident #7 had a diagnosis of Alzheimer's Dementia with behavioral disturbances. -Resident #7 could manifest an increase in behavioral disturbances if he missed several doses of Paroxetine. Interview with the Administrator on 09/26/19 at 3:50pm revealed: -If a medication was not on the cart or the medication count indicated it had not been administered as prescribed, that should be exposed during a cart audit. -The policy for cart audits was as follows: -The Physician Order Summary (POS) was printed from the computer and had all the active orders. -The MA, or whomever was assisting with the audit, used the POS and compared it to the orders on the eMAR and the medications on the cart. -Anything that did not match was pulled off the cart. -The medication tablets were counted and documented on the left margin of the POS. -The numbers were used to order refill medications if necessary.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 36 -The last cart audit was completed on 09/11/19. -When the cart audit was completed, the POS was given to the DRC to be reviewed. Review of the POS for the cart audit completed on 09/11/19 revealed Resident #7 had 3 tablets of Paroxetine remaining. There was no documentation in the Progress Notes dated 09/11/19 through 09/22/19 the staff attempted to contact the responsible family member and request a refill for Resident #7's Paroxetine. Attempted telephone interview with the prescribing physician on 09/26/19 at 4:25pm was unsuccessful. 3. Review of Resident #3's current FL2 dated 09/12/19 revealed diagnoses included Alzheimer's dementia, hypertension, hyperlipidemia and chronic pancreatitis. a. Review of Resident #3's physician's notes dated 09/03/19 revealed: -Resident #3 had a diagnosis of Type 2 diabetes mellitus. -Resident #3 was seen by his Primary Care Provider (PCP) on 09/03/19 for a hospital follow-up. -Resident #3 was sent to the emergency room (ER) on 09/01/19 because staff were unable to get an FSBS reading on his glucometer. -When Resident #3 arrived at the hospital, his FSBS was 469. -His BMP (basic metabolic panel; a blood test) showed a blood sugar result of 508. -Resident #3 was treated and returned to the facility on 09/02/19.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 37 Review of Resident #3's progress notes revealed: -On 09/01/19, Resident #3 was sent to the hospital for high blood sugar. -On 09/09/19, Resident #3's FSBS was 541 and Resident #3's PCP instructed the facility to send the resident to the ER. Review of Resident #3's physician orders dated 09/10/19 revealed an original order to start Humalog insulin per the following sliding scale: -If FSBS was 0-150, no insulin was to be administered. -If FSBS was 151-200: inject 4 units. -If FSBS was 201-250: inject 6 units. -If FSBS was 251-300: inject 8 units. -If FSBS was 301-350: inject 10 units. -If FSBS was 351-400: inject 12 units. -If FSBS was 401-449 inject 14 units. -If FSBS was greater than 450, inject 14 units and contact the physician. Review of Resident #3's ER discharge summary dated 09/09/19 revealed Resident #3 had been seen in the ER for hyperglycemia (high blood sugar) on 09/09/19. Review of Resident #3's current FL2 dated 09/12/19 revealed there was an order to check blood sugar before each meal and at night and inject Humalog Kwikpen 100 units/ml (a fast-acting insulin to treat diabetes) per the following sliding scale: -If fingerstick blood sugar (FSBS) was 0-150, no insulin was to be administered. -If FSBS was 151-200: inject 4 units. -If FSBS was 201-250: inject 6 units. -If FSBS was 251-300: inject 8 units. -If FSBS was 301-350: inject 10 units. -If FSBS was 351-400: inject 12 units. -If FSBS was 401-449 inject 14 units.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 38 -If FSBS was greater than 450, inject 14 units and contact the physician. Review of Resident #3's physician orders dated 09/13/19 revealed an order to discontinue Humalog Kwikpen insulin and start Novolog insulin (a fast-acting insulin to treat diabetes) per the following sliding scale: -If FSBS was 0-150, no insulin was to be administered. -If FSBS was 151-200: inject 4 units. -If FSBS was 201-250: inject 6 units. -If FSBS was 251-300: inject 8 units. -If FSBS was 301-350: inject 10 units. -If FSBS was 351-400: inject 12 units. -If FSBS was 401-449 inject 14 units. -If FSBS was greater than 450, inject 14 units and contact the physician. Review of Resident #3's September 2019 electronic medication administration record (eMAR) from 09/01/19-09/25/19 revealed: -There was an entry for Humalog Kwikpen insulin 100 units/ml to be administered per sliding scale at 7:00am, 12:00pm, 5:00pm and 8:00pm with a start date of 09/11/19 and a discontinue date of 09/13/19. -There was a block for entering the FSBS result, a block for entering the site of administration, and a block for entering the number of units administered for each administration time. -There was documentation Humalog Kwikpen had been administered correctly from 09/11/19 at 12:00pm through 09/13/19 at 12:00pm. -There was an entry for Novolog insulin 100 units/ml to be administered per sliding scale at 6:30am, 4:30pm, 8:00pm and 11:30pm with a start date of 09/13/19 and a discontinue date of 09/17/19. -There was a block for entering the FSBS result,	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 39 a block for entering the site of administration, and a block for entering the number of units administered at 6:30am and 11:30pm. -There was no documentation of the FSBS results, site of administration, or the number of insulin units administered at 6:30am or 11:30pm. -There were no blocks for entering the FSBS result, the site of administration or the number of insulin units administered at 4:30pm and 8:00pm. -There was no documentation of the FSBS results or Novolog administration from 09/13/19 at 4:30pm through 09/16/19 at 8:00pm for 14 consecutive doses. -There was an entry for Novolog insulin 100 units/ml to be administered per sliding scale at 6:30am, 11:30am, 4:30pm and 8:00pm with a start date of 09/17/19. -There was a block for entering the FSBS result, a block for entering the site of administration, and a block for entering the number of units administered for each administration time. -There was documentation Novolog insulin had been administered correctly from 09/17/19 at 6:30am through 09/25/19 at 12:00pm. Review of Resident #3's progress notes revealed there was no documentation of FSBS results or administration of Novolog insulin from 09/13/19-09/16/19. Observation of Resident #3's medications available for administration on 09/26/19 at 11:47am revealed there was a vial of Novolog insulin 100 units/ml available for administration with an open date of 09/14/19. Telephone interview with a representative with the facility's contracted pharmacy on 09/26/19 at 4:44pm revealed the pharmacy had dispensed one vial of Novolog insulin for Resident #3 on	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 40 09/13/19. Interview with a medication aide (MA) on 09/26/19 at 3:57pm revealed: -If a resident had an order for sliding scale insulin, the scale should populate on the eMAR when it was time to check the resident's FSBS and administer their insulin. -There should be a space to enter the result of the FSBS. -Once the FSBS was entered into the computer system, the system should automatically populate the amount of insulin to administer based on the sliding scale. -Once she administered the insulin, she would sign off on it as being administered. -There had been instances when there was no space to enter the FSBS result, and she would not administer any sliding scale insulin because the computer system would not populate the amount of insulin to administer. -She administered Resident #3's medications during the week of 09/13/19-09/16/19. -She could not recall there not being a space to enter the result of Resident #3's FSBS and could not remember not administering his sliding scale insulin. -If the FSBS result and insulin units administered was not documented on the eMAR, it meant she did not administer the insulin. Interview with the Resident Care Coordinator (RCC) on 09/27/19 at 9:59am revealed: -She was the RCC and a MA. -If a resident had an order for sliding scale insulin, the scale should populate on the eMAR when it was time to check the resident's FSBS and administer their insulin. -There should be a space to enter the result of the FSBS.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 41 -She did not routinely work as a MA, but when she had she did not recall the computer system automatically populating the amount of insulin to give based on the FSBS result. -She would administer the insulin by referring to the sliding scale order on the eMAR for that resident. -If there was no space to enter the FSBS results or the insulin units administered, the MAs should check the resident's FSBS, refer to the sliding scale to administer the proper amount of insulin and then document both the FSBS result and the insulin units administered in a progress note. -The MAs should alert the Director of Resident Care (DRC) if there was an issue with the computer system not allowing them to document the administration of medications. -She had administered medications to Resident #3 during the week of 09/13/19-09/16/19, but she could not recall checking his FSBS or administering sliding scale insulin. -She did not know there was no documentation of Resident #3's FSBS or sliding scale insulin administration for 14 consecutive doses. Telephone interview with Resident #3's PCP on 09/27/19 at 9:20am revealed: -She had been Resident #3's PCP since April 2019. -Resident #3 had a history of diabetes. -Prior to Resident #3's admission to this facility, he was hospitalized with a FSBS greater than 1000 and ketoacidosis (a potentially life-threatening problem that occurs when the body starts breaking down fat too fast, which causes the blood to become too acidic). -Resident #3's last Hgb A1C (a test that shows the average level of blood sugar over the past 2-3 months) was drawn on 09/17/19 and the result was 12.2 (the American Diabetes Association	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 42 recommends people with diabetes keep their Hgb A1C below 7.0). -She did not know Resident #3 had gone 3 days without having his FSBS checked and had missed 14 consecutive doses of Novolog sliding scale insulin from 09/13/19-09/16/19. -Resident #3 not having his FSBS checked and sliding scale insulin administered put him at risk for hyperglycemia with symptoms of dizziness, nausea, and fatigue. -If Resident #3's blood sugar became too high due to lack of insulin, it could result in ketoacidosis which could lead to coma and death. Interview with the Administrator on 09/27/19 at 9:00am revealed: -The facility's contracted pharmacy entered all medication orders onto the eMAR. -The DRC was then responsible for verifying the orders were entered correctly. -In the case of sliding scale insulin, the DRC had to verify the order was entered correctly including the times for checking the FSBS and administering insulin, and she also had to set the "calculator." -The DRC did not verify the times were correct for Resident #3's Novolog sliding scale insulin so instead of 11:30am, the time was set for 11:30pm. -Resident #3's sliding scale insulin "calculator" was not set correctly by the DRC so the computer system would not populate the amount of insulin to administer after the FSBS result was entered. -She was unsure why there was no box for entering the FSBS result at the 4:30pm and 8:00pm time slots. -The MA had brought the issue to her attention on 09/17/19, and she corrected it in the eMAR system. -If the MAs had checked Resident #3's FSBS and	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 43 administered sliding scale insulin but did not have a place to record the results on the eMAR, they should have recorded it in the progress notes. -If the MAs did not document in the progress notes, it meant they did not check the FSBS or administer insulin. b. Review of Resident #3's current FL2 dated 09/25/19 revealed there was an order for metformin 1000mg one tablet twice daily (an oral medication used to treat Type 2 diabetes). Review of Resident #3's physician's orders dated 09/03/19 revealed there was an order to discontinue metformin and start metformin 1000mg twice daily. Review of Resident #3's FL2 dated 08/13/19 revealed there was an order for metformin 500mg one tablet daily. Review of Resident #3's September 2019 eMAR (09/01/19-09/26/19) revealed: -There was an entry for metformin 500mg one tablet to be administered at 8:00am with a start date of 01/22/19 and a discontinue date of 09/09/19. -There was documentation metformin 500mg was administered once daily from 09/01/19-09/06/19 and again 09/08/19-09/09/19. -There was documentation metformin 500mg was not administered on 09/07/19 due to "duplicate." -There was a second entry for metformin, 1000mg, one tablet to be administered at 8:00am and 8:00pm daily with a start date of 09/03/19 and a discontinue date of 09/10/19. -There was documentation metformin 1000mg was administered at 8:00am from 09/05/19 through 09/10/19. -There was documentation metformin 1000mg	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 44 was not administered at 8:00am on 09/04/19 due to "duplicate orders." -There was documentation metformin 1000mg was administered at 8:00pm from 09/04/19 through 09/08/19. -There was documentation metformin 1000mg was not administered at 8:00pm on 09/09/19 due to Resident #3 being hospitalized. -There was a third entry for metformin, 1000mg, one tablet to be administered at 8:00am and 8:00pm daily with a start date of 09/10/19. -There was documentation metformin 1000mg was administered at 8:00am from 09/11/19 through 09/26/19. -There was documentation metformin 1000mg was administered at 8:00pm from 09/10/19 through 09/25/19. -There was documentation Resident #3 was administered both metformin 500mg and metformin 1000mg at 8:00am from 09/04/19 through 09/06/19 and again from 09/08/19 through 09/09/19 for 5 doses. Observation of Resident #3's medications available for administration on 09/26/19 at 11:47am revealed there was metformin 1000mg available for administration within multi-dose packages for both morning and evening doses dispensed on 09/25/19. Telephone interview with a representative with the facility's contracted pharmacy on 09/26/19 at 4:44pm revealed the pharmacy had dispensed a 7-day supply of metformin 1000mg two tablets daily for Resident #3 on 09/03/19, 09/07/19, 09/14/19, and 09/25/19. Interview with a medication aide (MA) on 09/26/19 at 3:57pm revealed: -When administering medications, she compared	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 45 the order on the eMAR to the directions on the medication prior to administration. -Resident #3's metformin was typically packaged in multi-dose packaging from the pharmacy. -It was likely Resident #3's metformin 500mg tablet was packaged in multi-dose packaging and when the order changed, the pharmacy sent a separate blister pack of metformin 1000mg tablets. -If both doses populated on the eMAR and both doses were available for administration, the MAs could have administered both. -Even though she had documented administration of both metformin doses, she could not recall there being two different doses that populated on the eMAR for administration. -If she had noticed two different doses of metformin on the eMAR, she would have checked with the Resident Care Coordinator (RCC) or Director of Resident Care (DRC). - "I don't think I would have administered both doses." Interview with a second MA on 09/27/19 at 8:25am revealed: -She always administered medications according to the eMAR. -She documented both metformin 500mg and metformin 1000mg was administered to Resident #3 "probably" because both doses populated on his eMAR. -She did not recall administering both doses of metformin and thought if she had seen two different doses, she should have clarified it with the DRC. Interview with the Resident Care Coordinator (RCC) on 09/27/19 at 9:45am revealed: -She was the RCC and a MA. -The facility's contracted pharmacy entered	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 46 medication orders onto the eMAR. -She or the DRC were responsible for verifying the medication orders were entered correctly prior to the MAs administering the medications. -Usually the medications would not populate in the computer system for administration until someone had verified the order was correct. -However, Resident #3's order for metformin 1000mg twice daily had populated in the computer system on 09/04/19 before she had the opportunity to verify it. -The MA told her Resident #3 had three entries on his eMAR for metformin including duplicate entries for metformin 1000mg twice daily and an additional entry for metformin 500mg. -The RCC documented on Resident #3's eMAR "duplicate orders" for metformin 1000mg at 8:00am on 09/04/19. -She discontinued one of the metformin 1000mg twice daily orders and verified the second metformin 1000mg twice daily order as correct. -She did not discontinue the metformin 500mg daily order from the eMAR on 09/04/19 and could not explain why. -She was Resident #3's MA on 09/07/19, and she documented metformin 500mg was not administered due to "duplicate order." -She administered Resident #3's metformin 1000mg on 09/07/19 at 8:00am and documented the administration on his eMAR. -She did not discontinue Resident #3's metformin 500mg order from the eMAR at that time because she was busy with her medication pass. -She did not remember Resident #3's metformin 500mg remained on the eMAR until another MA brought it to her attention on 09/09/19 at which time she discontinued it from the eMAR. -If MAs documented the administration of both doses, it confirmed both metformin 500mg and metformin 1000mg were administered to	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 47 Resident #3 at the same time. Telephone interview with Resident #3's Primary Care Provider (PCP) on 09/27/19 at 9:20am revealed: -She had been Resident #3's PCP since April 2019. -Resident #3 had a history of diabetes. -She had increased his dose of metformin from 500mg daily to 1000mg twice daily on 09/03/19 after his hospitalization for hyperglycemia. -She did not know both metformin 500mg and metformin 1000mg had been administered to Resident #3 for five days. -High doses of metformin could cause kidney and liver damage over a longer period. -She expected the facility to administer medications as ordered. Interview with the Administrator on 09/27/19 at 9:00am revealed: -The facility's contracted pharmacy entered all medication orders onto the eMAR. -The DRC was then responsible for verifying the orders were entered correctly. -The RCC verified Resident #3's metformin 1000mg twice daily order as correct on 09/04/19 but did not discontinue the previous order for metformin 500mg daily. -The MAs had administered both metformin 500mg and metformin 1000mg at 8:00am for five days because both orders remained on the eMAR. Attempted telephone interview with a third MA on 09/27/19 at 10:51am was unsuccessful. Attempted telephone interview with a second MA on 09/27/19 at 12:15pm was unsuccessful.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 48 4. Review of Resident #1's current FL2 dated 09/12/19 revealed: -Diagnoses included dementia, diabetes mellitus type 2, hypertension, and hyperlipidemia. -There was an order for quetiapine 50mg (used to treat mood disorders) take one and a half tablets twice daily. Review of Resident #1's physician's order revealed: -There was a physician's order dated 07/24/19 for quetiapine 25mg one tablet at bedtime. -There was a physician's order dated 08/07/19 for quetiapine 50mg one tablet at bedtime. -There was a physician's order dated 09/04/19 for quetiapine 25mg one tablet twice daily. -There was a physician's order dated 09/09/19 for quetiapine 75mg twice daily. Review of Resident #1's August 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for quetiapine 25mg one tablet daily at 8:00pm beginning 06/27/19-08/08/19. -Quetiapine 25mg was documented as administered daily at 8:00pm from 08/01/19-08/07/19. -There was an entry for quetiapine 50mg one tablet at 8:00pm beginning 08/07/19. -Quetiapine 50mg was documented as administered daily at 8:00pm from 08/08/19-08/31/19. Review of Resident #1's September 2019 eMAR revealed: -There was an entry for quetiapine 50mg one tablet at 8:00pm. -Quetiapine 50mg was documented as administered daily 09/01/19-09/04/19, the	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 49 resident refused on 09/05/19. -There was a second entry for quetiapine 25mg one tablet twice daily at 8:00am and 8:00pm. -Quetiapine 25mg was documented as administered twice daily at 8:00am and 8:00pm from 09/06/19-09/19/19. -There was a third entry for quetiapine 50mg, one and a half tablet (75mg) twice daily at 8:00am and 8:00pm. -Quetiapine 75mg was documented as administered twice daily from 09/10/19-09/25/19, the resident refused on 09/19/19 at 8:00am. Observation of Resident #1's medications on 09/25/19 at 3:25pm revealed: -There was a bubble pack containing 4 tablets of quetiapine 50mg dispensed on 08/07/19. -There was a bubble pack containing 11 tablets of quetiapine 25mg dispensed on 09/05/19. -There was a bubble pack containing 18 tablets of quetiapine 50mg dispensed on 09/09/19. -There was a bubble pack containing 20 half tablets of quetiapine 50mg dispensed on 09/09/19. -There was no multi-dose package containing quetiapine available for administration. Interview with a pharmacy technician at Resident #1's pharmacy on 09/26/19 at 9:35am revealed: -The pharmacy had a current order for quetiapine 75mg twice daily dated 09/09/19. -The pharmacy had a previous order for quetiapine 25mg one tablet at bedtime dated 07/24/19. -The pharmacy had a previous order for quetiapine 50mg one tablet at bedtime dated 08/07/19. -The pharmacy had a previous order quetiapine 25mg one tablet twice daily dated 09/04/19. -The pharmacy dispensed 28 tablets of	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 50 quetiapine 25mg on 07/05/19. -There were 7 tablets of quetiapine 25mg was dispensed on 08/02/19. -There were 16 tablets of quetiapine 25mg was dispensed on 09/05/19. -There were 31.5 tablets of quetiapine 50mg was sent on 09/09/19. -The facility used weekly multi-dose packaging, however not all medications were not included each week. -Some medications were included in the bubble pack if they were not in multi-dose packaging if an order changed after multi-dose packaging was delivered. -The pharmacy could not indicate which dates quetiapine was included in multi-dose packing. Interview with a medication aide (MA) on 09/26/19 at 12:20pm revealed: -She administered medications to Resident #1 when she worked. -She thought she administered quetiapine as ordered to Resident #1 as the medication was included in multi-dose packaging. -She noticed that the bubble packs containing quetiapine was on the cart however she did not administer the medication because it was in the multi-dose packaging. -The quetiapine bubble packs left on the cart were extra and she left them on the cart on purpose to see if they would be removed by someone else. Interview with a MA on 09/26/19 at 4:20pm revealed: -Resident #1's quetiapine was not always included in multi-dose packaging. -When the resident's orders changed, bubble packs were sent with the medication to be administered.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 51 -MAs were responsible for reading the multi-dose packaging and the MAR and if all medication were not included, they should check the cart for a bubble pack. -She did not realize there was quetiapine bubble packs on the cart to be administered until the surveyor completed observation of medication available for administration. Interview with a MA on 09/27/19 at 11:37am revealed: -She had not noticed quetiapine bubble packs were available for administration for Resident #1. -She thought all of Resident #1's medications were included in the multi-dose packaging. Interview with Resident #1's legal guardian on 09/27/19 at 9:34am revealed: -Resident #1 had a history of schizophrenia and bipolar disorder. -Resident #1's medications were delivered from the pharmacy and she was not sure if the resident received her medications as ordered. -Over the past month, she observed Resident #1 experiencing increased hallucinations. Interview with the Resident Care Coordinator (RCC) on 09/27/19 at 9:32am revealed: -She and the Director of Resident Care (DRC) were responsible for checking the eMAR with medications received from the pharmacy weekly. -She and the DRC also checked the cart weekly to ensure medications were available for administration. -The MAs were to read the multi-dose packaging and if the all medications were not included, they were to check the cart for a bubble pack. -She did not realize there were extra cards of quetiapine available on the cart for administration.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 52 Interview with Resident #1's primary care provider (PCP) on 09/26/19 at 4:33pm revealed: -She continued quetiapine for Resident #1 as ordered by the hospital when she was admitted to the facility. -Quetiapine was used to treat symptoms of paranoia and hallucinations in Resident #1. -If quetiapine was not administered as ordered the resident would experience increased paranoia, hallucinations. -She expected Resident #1 to receive medications as ordered. Interview with the Administrator on 009/27/19 at 10:20am revealed: -She expected MAs to administer medications as ordered. -MAs were to check the multi-dose packaging and the cart for a bubble pack to ensure all medications were administered. -"If the quetiapine was still on the cart, then it was not given". -MAs had been trained to read the multi-dose packaging when the switched the new process. 5. Review of Resident #5's FL2 dated 08/27/19 revealed diagnosis included dementia, hypothyroidism, and vitamin b deficiency. Review of Resident #5's physician's order dated 09/12/19 revealed there wasn an order for Zofran 4mg to be administered as needed for nausea and vomiting prior to meals. Review of Resident #5's electronic medication administration record (eMAR) for September 2019 revealed there was no entry for Zofran 4mg as needed. Observation of medication available for	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 53 administration on 09/25/19 at 3:25pm revealed Zofran 4mg was not available for administration. Interview with a medication aide (MA) on 09/26/19 at 10:40am: -MAs were not involved in processing orders received from the physician. -All orders were given to the Resident Care Coordinator (RCC) or the Director of Resident Care (DRC) to process. -If the medication did not appear on the eMAR it was not given. -She had not noticed a Zofran 4mg order for Resident #5. -Resident #5 had not complained to her about experiencing nausea. Interview with a pharmacy technician at the facility's contracted pharmacy on 09/26/19 at 9:35am revealed -The pharmacy did not receive an order for Zofran 4mg on 09/12/19. -Once orders are received from the facility, the order was entered on the eMAR by the pharmacy. Interview with the Resident Care Coordinator (RCC) on 09/26/19 at 10:17am revealed: -Physician's orders went to the Director or Resident Care (DRC) to be processed. -She would assist the DRC and fax orders to the pharmacy when requested. -The pharmacy would profile orders and she or the DRC would verify in the computer system. -She worked on 09/12/19, however did not remember seeing the order for Zofran 4mg for Resident #5. -She was not sure why the Zofran 4mg order was not faxed to the pharmacy. Interview with Resident #5 on 09/27/19 at 8:59am	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 54 revealed: -She had an upset stomach when she went to the doctor on 09/12/19. -Sometimes she gets nauseous and she asks for milk to help her stomach. Interview with the nurse for the primary care provider (PCP) on 09/26/19 at 4:15pm revealed: -The physician wrote an order for Zofran 4mg for nausea and vomiting related to gastroenteritis and dehydration that was diagnosed on 09/12/19. -The resident would be at risk for increased nausea and vomiting if Resident #5 experienced her symptoms of gastroenteritis. -The physician expected Zofran to be available to be administered to Resident #5 if needed. Review of a subsequent physician's order for Resident #5 dated 09/25/19 revealed Zofran 4mg was to be administered prior to meals for nausea and vomiting; up to one dose per day, if requiring more than one dose call the office back. Interview with the Administrator on 09/27/19 at 10:20am revealed: -The DRC was responsible for faxing orders to the pharmacy and verifying the order. -If the DRC was not available the RCC would assist with processing orders. -She expected all orders to be faxed to the pharmacy once received from the physician. -She did not know why the order for Resident #5's Zofran was not faxed, it should have been sent to the pharmacy. Based on observations and interviews, it was determined the DRC was not available for interview during the survey. The facility failed to assure medications were	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 55 administered as ordered and in accordance with the facility's policy for two residents observed during the medication pass, including errors with a scheduled dose of fast acting insulin not administered before a meal (Resident #6), and 2 of 5 sampled residents including sliding scale insulin not being administered for 14 consecutive doses putting the resident at risk for hyperglycemia, diabetic ketoacidosis, coma and death (Resident #3), and a scheduled fast acting insulin not administered for 15 doses with elevated blood sugar levels and a risk for diabetic ketoacidosis (Resident #6). This failure resulted in substantial risk of harm to the residents, which constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection for this violation in accordance with G.S. 131D-34 on 09/25/19. THE CORRECTION DATE SHALL NOT EXCEED OCTOBER 25, 2019 FOR THE TYPE A2 VIOLATION.	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment;	{D 367}	10A NCAC 13F .1004(j) Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (10 resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quanity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;(6)date and time of administration;(7) documentation of any omission of medications or treatments and the reason All orders will be reviewed for accuracy on the MAR- to include resident's name, name of the medication or treatment, strength and dosage or quanity to be administered, complete instructions for administration of the medication or treatment, reason or justifcation for the administration of any medication that is a as needed med or treatment and the documentation to show the effect on the resident, date and	Nov. 8, 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 56 (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure accuracy of the electronic medication administration records (eMARs) for 3 of 7 sampled residents (Residents #3, #6, and #7) related to scheduled insulin, sliding scale insulin and fingerstick blood sugars not able to be documented on the eMAR and were not administered (Residents #3 and #6), and a medication for mood stability documented as administered and not in the facility (Resident #7). The findings are: 1. Review of Resident #6's FL2 dated 09/12/19 revealed diagnoses included diabetes mellitus. a. There was an order for Novolog 100units/ml, (a	{D 367}	time of the adminstration, documentation of any omission of medication or treatments and the reason for the omission or refusals and (8) initials of the person administering the medication or treatment. If intials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR) All orders will be verified for accuracy before activation of order. RCC/MCM will be in charge of verification of all orders with ED oversight. All insulin orders will be verified and then they will be checked by ED to ensure accuracy. Any medications that come from an outside pharmacy such as VA will be checked in by the RCC/MCM to ensure that proper dosage is on the cart at all times. If meds need to be cut in half due to the dosage RCC/MCM will be responisble for this at time of arrival and before placing on the cart. A change order sticker will be placed on any bottle, vial, card or inhaler that is in requirement of this sticker. Med Techs and RCC/MCM will be responsible for the oversight of these applications to all meds. Med-Techs will be the first line of acknowledgment and RCC/MCM will oversee the applications. ED will follow up with a audit at least monthly to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 57 fast acting insulin used to control elevated blood glucose levels), administer 23 units three times a day before meals. Review of Resident #6's electronic medication administration record (eMAR) for September 2019 revealed: -There was an entry for Novolog insulin 100units/ml to be administered three times a day, scheduled for 6:30am, 12:00pm and 4:30pm. -There was no documentation Novolog 23 units was administered at 12:00pm on 09/20/19 or 09/25/19. -There was no progress note indicating an exception for administration of Novolog insulin on 09/20/19 or 09/25/19 at 12:00pm. -There was no documentation Novolog 23 units was administered at 4:30pm from 09/12/19 through 09/15/19 and 09/17/19 through 09/25/19. -There was no progress note indicating an exception for administration of Novolog insulin from 09/12/19 through 09/15/19 and 09/17/19 through 09/25/19. Interview with a medication aide (MA) on 09/26/19 at 3:15pm revealed: -There would be a drop down box on the eMAR to enter the site and administration of the insulin. -If there was no drop down box to enter the administration of the insulin, she would not administer the insulin. -She was one of the MAs who administered Resident #6's medications from 09/12/19 through 09/25/19. -There were no drop down boxes to enter documentation of the insulin administration during that time frame. -If the insulin units administered were not documented on the eMAR, it meant she did not administer the insulin.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 58 -She would have thought the order had changed. b. There was an order to check the fingerstick blood sugar (FSBS) before meals, three times a day. Review of Resident #6's electronic medication administration record (eMAR) for September 2019 revealed: -There was an entry for FSBS to be checked three times a day, at 6:30am, 12:00pm and 4:30pm. -There was no documentation FSBS was checked at 12:00pm on 09/20/19 or 09/25/19. -There was no progress note indicating a reason for the exception. -There was no documentation the FSBS was checked at 4:30pm from 09/12/19 through 09/15/19 and 09/17/19 through 09/25/19. -There was no progress note indicating a reason for the exception. Interview with a medication aide (MA) 09/26/19 at 3:15pm revealed: -There should be a drop down box on the eMAR to enter the results of the FSBS -If there was no drop down box to enter the FSBS result, she would not check the FSBS. -She was one of the MAs who administered Resident #6's medications from 09/12/19 through 09/25/19. -There were no drop down boxes to enter documentation of FSBS during that time frame. -If the FSBS result was not documented on the eMAR, it meant she did not check the FSBS. Interview with the Administrator on 09/27/19 at 9:00am revealed: -The facility's contracted pharmacy entered all medication orders onto the eMAR.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 59 -The Director of Resident Care (DRC) was then responsible for verifying the orders were entered correctly. -The DRC had to verify the drop down boxes were activated for the MAs to document the FSBS and the insulin administration. -If the MAs had checked Resident #6's FSBS and administered sliding scale insulin, but did not have a place to record the results on the eMAR, they should have recorded it in the progress notes. -If the MAs did not document in the progress notes, it meant they did not check the FSBS or administer insulin. Interview with the Resident Care Coordinator (RCC) on 09/27/19 at 9:59am revealed: -She was the RCC and a MA. -If a resident had an order for insulin, it would "pop" up and highlight in blue on the eMAR when it was time to check the resident's FSBS and administer their insulin. -There should be a space to enter the result of the FSBS, the site of the administration and the amount of insulin administered. -If the MAs found there was no drop down box to document the results, they should have documented the results in the progress notes and notified the DRC or the RCC. Attempted telephone interview with the DRC on 09/26/19 at 4:10pm was unsuccessful. 2. Review of Resident #7's current FL2 dated 09/12/19 revealed: - Diagnoses included Alzheimer dementia with behavioral disturbances, anoxic brain damage, convulsions and legal blindness. -There was an order for Paroxetine HCL 40mg, one half tablet (20mg), administer daily for mood	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 60 stability. Review of Resident #7's electronic medication administration record (eMAR) for September 2019 revealed: -There was an entry for Paroxetine 40 mg, one half tablet 20mg daily for mood stability. -There was documentation Paroxetine was administered on 09/18/19, and 09/20 through 09/26. -There was documentation Paroxetine was not administered on 09/17/19 and 09/18/19 due to the medication not in the facility. Observation of the medications on hand available for administration for Resident #7 on 09/26/19 at 8:45am revealed: -There was a bottle of Paroxetine with 12 whole tablets. -12 tablets were sent on 09/17/19, with directions to administer one half tab (20mg) daily. Based on observations of medications on hand and review of the September MAR and a cart audit on 09/11/19, there should only be seven and one half tablets remaining. Interview with a Medication Aide (MA) on 09/27/19 at 11:30am revealed: -She had administered Resident #7's medications on 09/17/19. -She had documented on the electronic progress notes "Not administered - RX order." -RX order was the documentation entered when a medication was not in the building and were awaiting its arrival. -On 09/19/19, the MA was administering Resident #7's medications and documented on the eMAR progress note "Not administered-RX order." -The MA informed the Director of Resident Care	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 61 (DRC) and the Resident Care Coordinator (RCC) Resident #7's Paroxetine was not in the facility to be administered. Interview with another MA on 09/26/19 at 3:15pm revealed: -She did not remember documenting the administration of Paroxetine to Resident #7 on 09/18/19, 09/21/19 and 09/22/19. -She could not explain why she had documented Paroxetine was administered to Resident #7 when there was documentation the medication was not in the building. Interview with the responsible family member on 09/27/19 at 10:20am revealed: -She brought the Paroxetine 40mg to the facility on Sunday, 09/22/19. -There were 12 tablets in the bottle. Interview with the Administrator on 09/26/19 at 3:50pm revealed: -If a medication was not on the cart, or the pill count indicated it had not been administered as prescribed, that should be exposed during a cart audit. -The last cart audit completed was on 09/11/19. -When the cart audit was completed, the report was given to the DRC to be reviewed. -The MAs should notify the DRC or RCC if a medication has 5 or less tablets and had not been dispensed. Review of the Physician Order Summary (POS) for the cart audit completed on 09/11/19 revealed Resident #7 had 3 tablets of Paroxetine remaining. 3. Review of Resident #3's current FL2 dated 09/12/19 revealed diagnoses included	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 62 Alzheimer's dementia, hypertension, hyperlipidemia and chronic pancreatitis. a. Review of Resident #3's current FL2 dated 09/12/19 revealed there was an order to check blood sugar before each meal and at night and inject Humalog Kwikpen 100 units/mL (a fast-acting insulin to treat diabetes) per the following sliding scale: -If fingerstick blood sugar (FSBS) was 0-150, no insulin was to be administered. -If FSBS was 151-200: inject 4 units. -If FSBS was 201-250: inject 6 units. -If FSBS was 251-300: inject 8 units. -If FSBS was 301-350: inject 10 units. -If FSBS was 351-400: inject 12 units. -If FSBS was 401-449 inject 14 units. -If FSBS was greater than 450, inject 14 units and contact the physician. Review of Resident #3's physician orders dated 09/10/19 revealed an order to start Humalog insulin per the following sliding scale: -If FSBS was 0-150, no insulin was to be administered. -If FSBS was 151-200: inject 4 units. -If FSBS was 201-250: inject 6 units. -If FSBS was 251-300: inject 8 units. -If FSBS was 301-350: inject 10 units. -If FSBS was 351-400: inject 12 units. -If FSBS was 401-449 inject 14 units. -If FSBS was greater than 450, inject 14 units and contact the physician. Review of Resident #3's physician orders dated 09/13/19 revealed an order to discontinue Humalog Kwikpen insulin and start Novolog insulin (a fast-acting insulin to treat diabetes) per the following sliding scale: -If FSBS was 0-150, no insulin was to be	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 63 administered. -If FSBS was 151-200: inject 4 units. -If FSBS was 201-250: inject 6 units. -If FSBS was 251-300: inject 8 units. -If FSBS was 301-350: inject 10 units. -If FSBS was 351-400: inject 12 units. -If FSBS was 401-449 inject 14 units. -If FSBS was greater than 450, inject 14 units and contact the physician. Review of Resident #3's September 2019 electronic medication administration record (eMAR) from 09/01/19-09/25/19 revealed: -There was an entry for Humalog Kwikpen insulin 100 units/mL to be administered per sliding scale at 7:00am, 12:00pm, 5:00pm and 8:00pm with a start date of 09/11/19 and a discontinue date of 09/13/19. -There was a block for entering the FSBS result, a block for entering the site of administration, and a block for entering the number of units administered for each administration time. -There was documentation Humalog Kwikpen had been administered correctly from 09/11/19 at 12:00pm through 09/13/19 at 12:00pm. -There was a second entry for Novolog insulin 100 units/mL to be administered per sliding scale at 6:30am, 4:30pm, 8:00pm and 11:30pm with a start date of 09/13/19 and a discontinue date of 09/17/19. -There was a block for entering the FSBS result, a block for entering the site of administration, and a block for entering the number of units administered at 6:30am and 11:30pm. -There were no blocks for entering the FSBS result, the site of administration or the number of units administered at 4:30pm and 8:00pm. -There was no documentation of the FSBS results or Novolog administration from 09/13/19 at 5:00pm through 09/16/19 at 8:00pm for 14	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 64 consecutive doses. -There was a third entry for Novolog insulin 100 units/mL to be administered per sliding scale at 6:30am, 11:30am, 4:30pm and 8:00pm with a start date of 09/17/19. -There was a block for entering the FSBS result, a block for entering the site of administration, and a block for entering the number of units administered for each administration time. -There was documentation Novolog insulin had been administered correctly from 09/17/19 at 6:30am through 09/25/19 at 12:00pm. Interview with a medication aide (MA) on 09/26/19 at 3:57pm revealed: -If a resident had an order for sliding scale insulin, the scale should populate on the eMAR when it was time to check the resident's FSBS and administer their insulin. -There should be a space to enter the result of the FSBS. -Once the FSBS was entered into the computer system, the system should automatically populate the amount of insulin to administer based on the sliding scale. -Once she administered the insulin, she would sign off on it as being administered. -There had been instances when there was no space to enter the FSBS result, and she would not administer any sliding scale insulin because the computer system would not populate the amount of insulin to administer. -She administered Resident #3's medications during the week of 09/13/19-09/16/19. -If the FSBS result and insulin units administered was not documented on the eMAR, it meant she did not administer the insulin. Attempted telephone interview with a second MA on 09/27/19 at 12:15pm was unsuccessful.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 65 Interview with the Resident Care Coordinator (RCC) on 09/27/19 at 9:59am revealed: -She was the RCC and a MA. -If a resident had an order for sliding scale insulin, the scale should populate on the eMAR when it was time to check the resident's FSBS and administer their insulin. -There should be a space to enter the result of the FSBS. -She did not routinely work as a MA, but when she had she did not recall the computer system automatically populating the amount of insulin to give based on the FSBS result. -She would administer the insulin by referring to the sliding scale order on the eMAR for that resident. -If there was no space to enter the FSBS results or the insulin units administered, the MAs should check the resident's FSBS, refer to the sliding scale to administer the proper amount of insulin and then document both the FSBS result and the insulin units administered in a progress note. -The MAs should alert the Director of Resident Care (DRC) if there was an issue with the computer system not allowing them to document the administration of medications. -She did not know there was no documentation of Resident #3's FSBS or sliding scale insulin administration for 14 consecutive doses. -The facility did not complete audits of the eMAR. -She assumed if the pharmacy had entered the order and a facility staff person had verified the order was correct, there was no need to audit the eMAR. Interview with the Administrator on 09/27/19 at 9:00am revealed: -The facility's contracted pharmacy entered all medication orders onto the eMAR.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 66 -The DRC was then responsible for verifying the orders were entered correctly. -In the case of sliding scale insulin, the DRC had to verify the order was entered correctly including the times for checking the FSBS and administering insulin, and she also had to set the "calculator." -The DRC did not verify the times were correct for Resident #3's Novolog sliding scale insulin so instead of 11:30am, the time was set for 11:30pm. -Resident #3's sliding scale insulin "calculator" was not set correctly by the DRC so the computer system would not populate the amount of insulin to administer after the FSBS result was entered. -She was unsure why there was no box for entering the FSBS result at the 4:30pm and 8:00pm time slots. -The MA had brought the issue to her attention on 09/17/19, and she corrected it in the eMAR system. -If the MAs had checked Resident #3's FSBS and administered sliding scale insulin but did not have a place to record the results on the eMAR, they should have recorded it in the progress notes. -If the MAs did not document in the progress notes, it meant they did not check the FSBS or administer insulin. -She knew medication cart and eMAR audits had been completed on 09/11/19 and 09/17/19. -Audits should be completed by Thursday of each week by the MAs. b. Review of Resident #3's current FL2 dated 09/25/19 revealed there was an order for metformin 1000mg one tablet twice daily (an oral medication used to treat Type 2 diabetes). Review of Resident #3's physician's orders dated 09/03/19 revealed there was an order to	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 67 discontinue metformin and start metformin 1000mg twice daily. Review of Resident #3's FL2 dated 08/13/19 revealed there was an order for metformin 500mg one tablet daily. Review of Resident #3's September 2019 eMAR (09/01/19-09/26/19) revealed: -There was an entry for metformin 500mg one tablet to be administered at 8:00am. -There was documentation metformin 500mg was administered daily from 09/01/19-09/06/19 and again 09/08/19-09/09/19. -There was documentation metformin 500mg was not administered on 09/07/19 due to "duplicate." -There was a second entry for metformin 1000mg one tablet to be administered at 8:00am and 8:00pm daily with a start date of 09/03/19 and a discontinue date of 09/10/19. -There was documentation metformin 1000mg was administered at 8:00am from 09/05/19 through 09/10/19. -There was documentation metformin 1000mg was not administered at 8:00am on 09/04/19 due to "duplicate orders." -There was documentation metformin 1000mg was administered at 8:00pm from 09/04/19 through 09/08/19. -There was documentation metformin 1000mg was not administered at 8:00pm on 09/09/19 due to Resident #3 being hospitalized. -There was a third entry for metformin 1000mg one tablet to be administered at 8:00am and 8:00pm daily with a start date of 09/10/19. -There was documentation metformin 1000mg was administered at 8:00am from 09/11/19 through 09/26/19. -There was documentation metformin 1000mg was administered at 8:00pm from 09/10/19	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 68 through 09/25/19. -There was documentation Resident #3 was administered both metformin 500mg and metformin 1000mg at 8:00am from 09/04/19 through 09/06/19 and again from 09/08/19 through 09/09/19 for 5 doses. Interview with a medication aide (MA) on 09/26/19 at 3:57pm revealed: -When administering medications, she compared the order on the eMAR to the directions on the medication prior to administration. -Resident #3's metformin was typically packaged in multi-dose packaging from the pharmacy. -It was likely Resident #3's metformin 500mg tablet was packaged in multi-dose packaging and when the order changed, the pharmacy sent a separate blister pack of metformin 1000mg tablets. -If both doses populated on the eMAR and both doses were available for administration, the MAs could have administered both. -Even though she had documented administration of both metformin doses, she could not recall there being two doses entered on the eMAR. -If she had noticed two different doses of metformin on the eMAR, she would have checked with the Resident Care Coordinator (RCC) or Director of Resident Care (DRC). - "I don't think I would have administered both doses." Interview with a second MA on 09/27/19 at 8:25am revealed: -She always administered medications according to the eMAR. -She documented both metformin 500mg and metformin 1000mg was administered to Resident #3 "probably" because both doses populated on his eMAR.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 69 -She did not recall administering both doses of metformin and thought if she had seen two different doses, she should have clarified it with the DRC. Interview with the Resident Care Coordinator (RCC) on 09/27/19 at 9:45am revealed: -She was the RCC and a MA. -The facility's contracted pharmacy entered medication orders onto the eMAR. -She or the DRC were responsible for verifying the medication orders were entered correctly prior to the MAs administering the medications. -Usually the medications would not populate in the computer system for administration until someone had verified the order was correct. -However, Resident #3's order for metformin 1000mg twice daily had populated in the computer system on 09/04/19 before she had the opportunity to verify it. -The MA told her Resident #3 had three entries on his eMAR for metformin including duplicate entries for metformin 1000mg twice daily and an additional entry for metformin 500mg. -She documented on Resident #3's eMAR "duplicate orders" for metformin 1000mg at 8:00am on 09/04/19. -She discontinued one of the metformin 1000mg twice daily orders and verified the second metformin 1000mg twice daily order as correct on 09/04/19. -She did not discontinue the metformin 500mg daily order from the eMAR on 09/04/19 and could not explain why. -She was Resident #3's MA on 09/07/19, and she documented metformin 500mg was not administered due to "duplicate order." -She administered Resident #3's metformin 1000mg on 09/07/19 at 8:00am and documented the administration on his eMAR.	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 70 -She did not discontinue Resident #3's metformin 500mg order from the eMAR at that time because she was busy with her medication pass. -She did not remember Resident #3's metformin 500mg remained on the eMAR until another MA brought it to her attention on 09/09/19 at which time she discontinued it from the eMAR. -If MAs documented the administration of both doses, it confirmed both metformin 500mg and metformin 1000mg were administered to Resident #3 at the same time. -The facility did not complete audits of the eMAR. -She assumed if the pharmacy had entered the order and she or the DRC had verified the order was correct, there was no need to audit the eMAR. Interview with the Administrator on 09/27/19 at 9:00am revealed: -The facility's contracted pharmacy entered all medication orders onto the eMAR. -The DRC was then responsible for verifying the orders were entered correctly. -The RCC verified Resident #3's metformin 1000mg twice daily order as correct on 09/04/19 but did not discontinue the previous order for metformin 500mg daily. -The MAs had administered both metformin 500mg and metformin 1000mg at 8:00am for five days because both orders remained on the eMAR. -She knew eMAR audits had been completed on 09/11/19 and 09/17/19. The facility failed to assure the electronic medication administration records (eMARs) were accurate for 3 of 7 samples residents (Resident #3, #6, #7) resulting in 15 scheduled doses of insulin not administered to a diabetic resident with documented elevated blood sugar levels over	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 71 450, which were hyperglycemic levels, (Resident #6) and sliding scale insulin that was not administered for 14 consecutive doses placing the resident at risk for ketoacidosis (Resident #3). The facility's failure increased the risk for medication errors which was detrimental to the health and safety of the residents and constitutes a Type B Violation. A Plan of Protection in accordance with G.S. 131D-34 was requested on 09/27/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 11, 2019.	{D 367}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care and medication administration.	{D912}	G.S 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. Staff will be inserviced on Resident Rights by community on line studies. Also staff will be inserviced by our Area Ombudsman on the next available date for training. Community will ensure that all residents' rights are upheld and followed by reminders and auditing to ensure daily compliance. This will be ongoing monitoring by the RCC/MCM and the ED on a daily routine.	11-14-2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D912}	Continued From page 72 The findings are: 1. Based on observations, interviews, and record reviews the facility failed to assure referral and follow up for 2 of 6 sampled residents related to notifying the physician for blood sugar levels above the parameters set by the physician (Resident #6) and not notifying the physician of refusals of insulin and delayed mental health referral (Resident #1). [Refer to Tag 0273 10A NCAC 13F .0902 (b) Health Care (Type A2 Violation)] 2.Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 6 residents observed during the medication pass (Residents #6 and #7) , including a scheduled fast acting insulin dosage not administered before lunch (Resident #6) and a scheduled mood stabilizer administered as ordered (Resident #7), and for 3 of 5 residents sampled for review (Residents #1, #3 and #5) including errors with a fast acting insulin and oral medication used to treat Type 2 diabetes (Resident #3), failure to administer antipsychotic medication as ordered (Resident #1), and failure to have a medication ordered for nausea available for administration (Resident #5). [Refer to Tag 0358 10A NCAC 13F .1004(a)(1) Medication Administration (Type A2 Violation)]. 3. Based on record reviews and interviews, the facility failed to assure accuracy of the electronic medication administration records (eMARs) for 3 of 7 sampled residents (Residents #3, #6, and #7) related to scheduled insulin, sliding scale insulin and fingerstick blood sugars not able to be documented on the eMAR and were not administered (Residents #3 and #6), and a	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060125	A. BUILDING: _____ B. WING _____	R 09/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D912}	Continued From page 73 medication for mood stability documented as administered and not in the facility (Resident #7). [Refer to Tag 0367 10A NCAC 13F .1004(j) Medication Administration (Type B Violation)]	{D912}		