PRINTED: 11/14/2019
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 an annual survey on 10/23/19 to 10/24/19.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or conclusions; set forth in the statement of deficiencies, the plan of correction is prepared soley as a matter of compliance with the law.	
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) was tested upon hire for Tuberculosis (TB) disease. The findings are: Review of Staff B's, Medication Aide (MA), personnel record revealed: -She was hired on 09/25/19. -There was documentation of a negative TB skin test read on 04/12/19. -There was no documentation of a second TB skin test. Interview with the Business Office Manager on 10/23/19 at 3:35pm revealed: -She had just recently been employed at the facility. -She was responsible for maintaining the	D 131	10 A NCAC 13F .0406(a) Test for Tuberculosis Employee file audits to be completed by community management (Executive Director and or Assistant ED) to ensure all currently employed staff have been tested for Tuberculosis per DHHS rules and regulations Any staff without TB test to meet regulations will be immediately given the appropriate TB step and results will be filed in employee record. Employee file audit will include a check list for all ongoing new hires to assure TB testing is completed in full, in a timely manner. Routine file audits will occur with a review check list for accuracy. Community management to coordianate with LHPS nurse scheduling of 2 step TB within the first 14 days of orientation or employee to be removed from scheduled until tuberculosis screening has been completed.	12/08/19 12/08/19 12/08/19

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Camilla Sherrill
Executive Director
12-09-19

Reviewed and Accepted 12/17/19 RH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 131	Continued From page 1 personnel records. -The Special Care Coordinator (SCC) and the Administrator were responsible for scheduling appointments with the facility's Licensed Health Professional Support (LHPS) nurse for new employees to receive TB skin tests. Telephone interview with Staff B on 10/24/19 at 3:30pm revealed: -She had a TB skin test that was read on 04/12/19. -She had not had a second TB skin test. Interview with the Administrator on 10/23/19 at 4:57pm revealed: -She thought they could use a prior TB skin test if it had been within the last 12 months as the first step TB skin test. -She thought the second step TB skin test had to be completed within 12 months of the first TB skin test. -"Typically" the facility would get a second TB skin test within the first 30 days of employment. -The corporate policy on TB skin testing for new employees was to follow the state rules and regulations regarding TB testing.	D 131		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 2 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a physician for 3 of 6 residents (#2, #6 and #7) observed during the medication pass related to administering the incorrect dose of a medication for depression (#7), an inhaler used for lung disease and a cough syrup (#6), administered duplicate medications for blood pressure (#2), and did not administer a medication for acid reflux (#6). The findings are: The medication error rate was 15% as evidenced by 5 errors out of 32 opportunities observed during the medication pass on 10/24/19 at 8:16am. 1. Review of Resident #7's current FL2 dated 03/07/19 revealed: -Diagnoses included Alzheimer's Disease, hypertension, osteoarthritis, and esophageal reflux. -There was a physician's order for sertraline 100mg take 1 tablet daily (used to treat anxiety and depression). Review of Resident #7's physician's order dated 08/09/19 revealed a physician's order for sertraline 100mg take 1 and ½ tablets (150mg) daily. Observation of medication pass on 10/24/19 at 9:05am revealed the medication aide (MA) administered a half tablet of sertraline 100mg (to equal 50mg) to Resident #7. Review of Resident #7's October 2019 electronic	D 358	10 A NCAC 13F .1004 (a) Medication Administration Community management (Executive Director and or Memory Care Manager) to complete medication cart audit with focus on new orders as well as duplicate orders. Community pharmacy has now implamented MDP medication Community Management to continue routine medication order audits weekly, community third shift SIC to continue weekly cart audits. Community management to complete random medication administration observation twice weekly for thirty days, once a month thereafter. Community LHPS nurse to complete in service with medication staff with training focused on the six rights on medication administration and reporting discrepancies to MCM and or ED for follow up	11/12/19 11/12/19 11/12/19 11/08/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 3 Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for sertraline 100mg take 1 and ½ tablets every morning scheduled to administer daily at 9:00am. -Sertraline 100mg 1 and ½ tablets was documented as administered daily from 10/01/19 to 10/23/19. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/24/19 at 12:30pm revealed: -The pharmacy dispensed two medication cards of sertraline for Resident #7 on 10/04/19 to cover a thirty-day supply. -One medication card had 30 doses of 100mg tablets and the second card had 30 doses of 50mg tablets (100mg half tablets) both dispensed on 10/04/19. -The facility was responsible for administering 1 whole tablet and one ½ tablet to Resident #7 daily to equal the prescribed dose of 150mg daily. -The original medication order was written on 08/10/19. Observation of Resident #7's medications on hand on 10/24/19 at 4:30pm revealed: -One medication card had 30 doses of 100mg tablets and the second card had 24 doses of 50mg tablets (100mg half tablets) both dispensed on 10/04/19. -The prescription label on both medication cards had the same directions to take 1.5 tablets daily. Interview with a MA on 10/24/19 at 9:05am revealed: -She thought she had administered the correct dose of sertraline to Resident #7. -She did not know there was another medication card of sertraline containing whole tablets.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 4	D 358		

-She and other facility staff had to monitor Resident #7 or she would isolate herself in her room.

Telephone with Resident #7's Physician Assistant (PA) on 10/24/19 at 3:05pm revealed:
-Resident #7 was prescribed sertraline during a hospitalization in March 2019 for the treatment of depression and making suicidal statements.
-It was important for Resident #7 to take her sertraline as prescribed.
-Resident #7 was at an increased risk for behavior disturbances, including increased depression, suicidal ideation, agitation, anxiety, and an increased tendency to isolate herself from other residents and staff.

Telephone interview with Resident #7's mental health provider on 10/24/19 at 4:57pm revealed:
-Resident #7 was at an increased risk of irritability if she did not receive her sertraline as prescribed.
-The facility was responsible for making sure medications were administered to the residents based on the physician's orders.

Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/24/19 at 12:30pm.

Refer to the interview with a MA on 10/24/19 at 10:55am.

Refer to the interview with the RCC on 10/23/19 at 4:25pm and 10/24/19 at 12:05pm.

Refer to the interview with the ED on 10/24/19 at 1:10pm.

2. Review of Resident #2's current FL2 dated 03/05/19 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 5 -Diagnoses included vascular dementia, metabolic encephalopathy, hypertension and diabetes. -There was a physician's order for metoprolol succinate extended release (ER) 50mg take 1 tablet daily (used to treat high blood pressure). Review of Resident #2's record revealed: -There was a prior authorization request dated 10/04/19 from the resident's prescription insurance plan for approval to cover Kapspargo 50mg ER capsules (used to treat high blood pressure). -The document was not signed by a physician. Review of Resident #2's record revealed a signed physician's order dated 10/20/19 to discontinue metoprolol succinate 50mg take 1 tablet daily and begin metoprolol succinate ER 50mg take 1 tablet twice daily. a. Observation of the medication pass on 10/24/19 at 8:42am revealed Resident #2 was not administered metoprolol succinate ER 50mg. Review of Resident #2's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for metoprolol succinate ER 50mg take 1 tablet daily scheduled to administer daily at 8:00am. -Metoprolol succinate ER was documented as administered daily at 8:00am on 10/01/19 and 10/02/19. -There was documentation on 10/03/19 that metoprolol succinate ER 50mg take 1 tablet daily was discontinued on 10/03/19. -There was a computer-generated entry for metoprolol succinate ER 50mg take 1 tablet twice daily scheduled to administer daily at 8:00am and	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 6	D 358		

8:00pm with a start date of 10/03/19.
-Metoprolol succinate ER 50mg was documented as administered twice daily from 10/03/19 to 10/23/19.

Observation of medications on hand for Resident #2 on 10/24/19 at 10:05am revealed:
-There were two medication cards containing metoprolol succinate ER 50mg available to administer to Resident #3.
-One medication card originally contained 30 tablets of metoprolol succinate ER 50mg dispensed on 09/05/19 and had 1 tablet remaining.
-The second medication card originally contained 14 tablets of metoprolol succinate ER 50mg dispensed on 10/02/19 and had 11 tablets remaining.

Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/24/19 at 12:30pm.

Refer to the interview with a MA on 10/24/19 at 10:55am.

Refer to the interview with the RCC on 10/23/19 at 4:25pm and 10/24/19 at 12:05pm.

Refer to the interview with the ED on 10/24/19 at 1:10pm.

b. Observation of the medication pass on 10/24/19 at 8:42am revealed Resident #2 was administered Kapspargo 50mg along with his other morning medications.

Review of Resident #2's October 2019 electronic Medication Administration Record (eMAR) revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 7 -There was a computer-generated entry for Kapspargo ER 50mg take 1 capsule twice daily scheduled to administer at 8:00am and 8:00pm with a start date of 10/03/19. -Kapspargo ER 50mg was documented as administered twice daily from 10/10/19 to 10/23/19. Observation of medications on hand for Resident #2 on 10/24/19 at 10:05am revealed: -There were 60 capsules of Kapspargo dispensed to Resident #2 on 10/09/19. -There was 1 medication card containing 11 capsules of Kapspargo available to administer with a second medication card containing 30 capsules also available in the medication cart. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/24/19 at 12:30pm revealed: -The pharmacy received a signed electronic medication order for Kapspargo from Resident #2's PA for Kapspargo dated 10/02/19. -The pharmacist clarified the medication order with Resident #2's PA when they received the Kapspargo medication before it was dispensed because the resident was already prescribed metoprolol succinate. -Kapspargo and metoprolol succinate were identical medications except one was a capsule and the other was a tablet. -The pharmacy received an order to discontinue the metoprolol succinate and continue the Kapspargo for Resident #2 and the order was discontinued on the eMAR for facility approval. -The pharmacy had to get a prior authorization from Resident #2's insurance to cover the Kapspargo. -The pharmacy dispensed 60 capsules of Kapspargo on 10/09/19.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 8	D 358		

-The pharmacy received a new medication order on 10/20/19 written by Resident #2's PA to discontinue metoprolol succinate ER 50mg once daily and start metoprolol succinate ER 50mg twice daily but this order was entered on the eMAR for approval.
-The metoprolol succinate ER order from 10/20/19 was not clarified by the pharmacy.
-The pharmacy had a current medication order for Kapspargo 50mg and metoprolol succinate ER 50mg since 10/20/19.
-The pharmacy dispensed 30 tablets of metoprolol succinate ER 50mg on 08/06/19 and 09/05/19, 14 tablets on 10/02/19, and 60 tablets on 10/09/19.

Review of Resident #2's record revealed there was no medication order for Kapspargo 50mg or a discontinuation order for metoprolol succinate ER 50mg dated 10/02/19.

Telephone interview with Resident #2's Physician Assistant (PA) on 10/24/19 at 3:05pm revealed:
-She had received a refill request at the beginning of October for Kapspargo 50mg for Resident #2.
-She did not know why she received the request and was not familiar with the medication.
-Kapspargo was metoprolol succinate extended release (ER) available as a capsule instead of a tablet.
-Metoprolol succinate ER tablets and Kapspargo capsules had the same active ingredient and worked similarly in the body to lower blood pressure and heart rate.
-Resident #2 should not be taking both medications but she did not care which medication the resident continued.
-Resident #2 was at an increased risk for low blood pressure and bradycardia (low heart rate) if both formulations were administered together.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 9 -She was more concerned with the risk of bradycardia for Resident #2 which would increase the risk for dizziness, fatigue, and sleepiness which could lead to falls. Interview with a first shift medication aide (MA) on 10/24/19 at 10:55am revealed: -Resident #2 had both metoprolol succinate ER 50mg and Kapspargo 50mg on his eMAR. -She did not know the two medications were similar. -She knew Resident #2 was getting both medications on "some days" because they were both listed as active orders on the eMAR. -She followed the orders on the eMAR to know what medications to administer to the residents. Interview with the Resident Care Coordinator (RCC) on 10/24/19 at 12:05pm revealed: -She did not know Resident #2's eMAR had Kapspargo as active medication. -Sometimes the PA sent medication orders directly to the pharmacy. -She was responsible for tracking down a medication order if a medication appeared on the eMAR from the pharmacy, but the facility did not have the order. -She was responsible for verifying new medication orders before approving the order to appear on the eMAR. -She compared the order on the eMAR to the medication order from the physician. -She did not know why the medication order from 10/02/19 was not in Resident #2's record or how the orders were approved for the eMAR. -If she discontinued a medication from the eMAR, the medication order may reappear if the pharmacy dispensed a refill before processing a discontinued medication order. -She had to monitor the eMARs to make sure the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 10 discontinued medications did not reappear on the eMAR. Interview with the Executive Director (ED) on 10/24/19 at 1:10pm revealed: -She did not know the MAs were administering both forms of metoprolol succinate to Resident #2. -She did not know how both medication orders for metoprolol succinate and Kapspargo ended up on the eMAR. -She had contacted the facility's contracted pharmacy to fax over the medication order for Kapspargo. Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/24/19 at 12:30pm. Refer to the interview with a MA on 10/24/19 at 10:55am. Refer to the interview with the RCC on 10/23/19 at 4:25pm and 10/24/19 at 12:05pm. Refer to the interview with the ED on 10/24/19 at 1:10pm. 3. Review of Resident #6's current FL2 dated 07/11/19 revealed diagnoses included dementia, end stage renal disease (ESRD), chronic obstructive pulmonary disease (COPD), and interstitial lung disease. a. Review of Resident #6's current FL2 dated 07/11/19 revealed there was a physician's order for Flovent 110mcg inhale 1 puff every 12 hours (used to treat asthma and lung disease). Observation of the medication pass on 10/24/19	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 11	D 358		

at 8:16am revealed:
-The medication aide (MA) administered 2 puffs of Flovent 110mcg to Resident #6 with a few seconds between the puffs and instructed the resident to rinse his mouth out with water.
-Resident #6 stated he did not get any of the last puff and the MA administered an additional puff to the resident.

Review of Resident #6's October 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Flovent 110mcg inhale 1 puff twice daily - rinse mouth with water after use; do not swallow scheduled to administer daily at 8:00am and 8:00pm.
-Flovent was documented as administered twice daily at 8:00am and 8:00pm from 10/01/19 to 10/24/19.

Observation of medications on hand for Resident #6 on 10/24/19 at 4:30pm revealed there was one Flovent 110mcg inhaler available to administer with 60 doses of medication remaining dispensed on 07/13/19.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/24/19 at 12:30pm revealed:
-The pharmacy last dispensed one inhaler of Flovent 110mg to Resident #6 on 07/13/19.
-Each inhaler contained 120 puffs to cover a 60-day supply based on the directions to inhale 1 puff twice daily.

Interview with the Resident Care Coordinator (RCC) on 10/24/19 at 12:05pm revealed:
-She had only worked at the facility for about a month.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 12 -She did not know Resident #6 was administered the incorrect dose of Flovent. -The third shift MAs were responsible for auditing the medication carts to make sure medications were available for administration. -She had not audited the medication carts to review medication quantities since she had started working in the facility. Telephone with Resident #6's Physician Assistant (PA) on 10/24/19 at 3:05pm revealed: -She did not know Resident #6 was not getting the Flovent administered correctly based on the order. -The RCC had informed her of the medication error this morning (10/24/19). -Resident #6 was prescribed Flovent for his lung disease. -It was important for him to take his medication daily to prevent a "flare" of his COPD where he would have increased shortness of breath. -The facility was responsible for administering medications to the residents based on the physician's orders. Interview with the Executive Director (ED) on 10/24/19 at 1:10pm revealed: -She did not know Resident #6 was administered the incorrect dose of Flovent. -She did not audit the medication carts. -The MAs and the RCC were required the audit the medication carts. Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/24/19 at 12:30pm. Refer to the interview with a MA on 10/24/19 at 10:55am.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 Refer to the interview with the RCC on 10/23/19 at 4:25pm and 10/24/19 at 12:05pm. Refer to the interview with the ED on 10/24/19 at 1:10pm. b. Review of Resident #6's current FL2 dated 07/11/19 there was a physician's order for pantoprazole 20mg take 1 tablet daily (used to treat acid reflux and heartburn). Observation of the medication pass on 10/24/19 at 8:16am revealed: -The medication aide (MA) pulled all the medication cards for Resident #6 out of the medication cart and laid them on top of the cart. -She compared the medication cards to the electronic Medication Administration Record (eMAR). -The MA administered 4 tablets to Resident #6 in the dining hall, but the medication cup did not contain the pantoprazole. Review of Resident #6's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for pantoprazole 20mg take 1 tablet daily - do not crush or chew scheduled to administer daily at 9:00am. -Pantoprazole was documented as administered daily at 9:00am from 10/01/19 to 10/23/19. -There was documentation on 10/24/19 that the medication was not administered the provider was notified. Observation of medications on hand for Resident #6 on 10/24/19 at 4:30pm revealed there were 25 tablets of pantoprazole 20mg available to administer dispensed on 10/04/19 with an original	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 14 dispensed quantity of 30. Interview with the MA on 10/24/19 at 9:05am revealed: -She knew Resident #6 was administered pantoprazole in the mornings. -She did not realize that she did not administer pantoprazole to Resident #6 along with his other morning medications on 10/24/19. Telephone with Resident #6's Physician Assistant (PA) on 10/24/19 at 3:05pm revealed: -The RCC had called her and informed her of the medication error this morning (10/24/19). -She ordered the pantoprazole for Resident #6 because he was experiencing some heart burn in the past. -The facility was responsible for administering medications as ordered by a physician. -She gave a verbal order to hold the pantoprazole today and resume the medication the following day. Interview with the Executive Director (ED) on 10/24/19 at 1:10pm revealed: -She did not know Resident #6 was not administered the pantoprazole during the morning medication pass. -The MAs were responsible for administering medications. Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/24/19 at 12:30pm. Refer to the interview with a MA on 10/24/19 at 10:55am. Refer to the interview with the RCC on 10/23/19 at 4:25pm and 10/24/19 at 12:05pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 15	D 358		

Refer to the interview with the ED on 10/24/19 at 1:10pm.

c. Review of Resident #6's record revealed a standing order dated 04/09/19 for Robitussin 2 teaspoonfuls (10ml) every 6 hours as needed for cough - not to exceed 4 doses (used for cough).

Observation of the medication pass on 10/24/19 at 8:16am revealed:
-Resident #6 asked for a medication for cough after the medication aide (MA) had administered his scheduled morning medications.
-The MA poured 30ml of Geri-tussin (guafenesin) in a 1-ounce plastic dose cup.
-The bottle of Geri-tussin was not labeled with a residents name.
-The MA administered the Geri-tussin to Resident #6.
-Resident #6 drank the entire 30ml of Geri-tussin

Review of Resident #6's October 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Robafen (generic for Robitussin)100mg/5ml take 30ml every 6 hours as needed for cough - not to exceed 4 doses scheduled as an as needed medication.
-Robafen was documented as administered on 10/24/19 at 8:41am.

Observation of medications on hand for Resident #6 on 10/24/19 at 8:30am revealed there was a partially used 473ml bottle of Geri-Tussin (generic for Robitussin) 100mg/5ml available to administer.

Interview with the MA on 10/24/19 at 9:05am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 16	D 358		

revealed:
-She administered the cough syrup based on the directions on the eMAR.
-She did not know the order was entered incorrectly on the eMAR.
-Resident #6 was administered the Geri-Tussin from a bottle used as stock for the facility.

Interview with the Resident Care Coordinator (RCC) on 10/24/19 at 12:05pm revealed:
-She did not know Resident #6 was administered the incorrect dose of Geri-Tussin.
-She did not know the standing order was entered on the eMAR incorrectly for Resident #6.
-She had called the pharmacy and a pharmacy representative told her the medication ordered was entered incorrectly from the pharmacy.
-The order was entered on the eMAR before she started working at the facility.
-She was not sure how the order got approved on the eMAR incorrectly.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/24/19 at 12:30pm revealed:
-The Robafen was considered a standing order for the facility.
-The standing orders were "profiled" for a resident so the order would appear on the resident's eMAR but never dispensed.
-The standing order for Robafen for Resident #6 was entered incorrectly at the pharmacy.
-The order was entered to take 2 tablespoonfuls instead of 2 teaspoonfuls.
-The facility was responsible for approving the medication orders from the pharmacy before they appeared on the eMAR.

Telephone with Resident #6's Physician Assistant (PA) on 10/24/19 at 3:05pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 17	D 358		

-The facility had called her and informed her of the medication error this morning (10/24/19).
-She was glad Resident #6 had only received one dose of the cough syrup with the incorrect dose.
-The facility was responsible for administering medications as orders by a physician.

Interview with the Executive Director (ED) on 10/24/19 at 1:10pm revealed:
-She did not know the medication order from Geri-tussin for Resident #6 was entered on the eMAR incorrectly.
-She, the RCC, and the MAs were responsible for making sure all new medication orders were accurate on the eMARs.
-The RCC was responsible for giving her a copy of all the medication orders and she would compare the order to the eMAR for accuracy.

Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/24/19 at 12:30pm.

Refer to the interview with a MA on 10/24/19 at 10:55am.

Refer to the interview with the RCC on 10/23/19 at 4:25pm and 10/24/19 at 12:05pm.

Refer to the interview with the ED on 10/24/19 at 1:10pm.

____

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/24/19 at 12:30pm revealed:
-The pharmacy was responsible for entering new medication orders on the electronic Medication Administration Record (eMAR).
-The facility was responsible for approving all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 18 medication orders before the order appeared on the eMAR. -The pharmacy was responsible for discontinuing medications on the eMAR but the facility was still responsible for approving discontinued orders before the medications were removed from the eMAR. Interview with a medication aide (MA) on 10/24/19 at 10:55am revealed: -The MAs were responsible for administering medications based on the eMAR. -The Resident Care Coordinator (RCC) or the MAs were responsible for medication order approvals for the eMAR. -The third shift MAs were responsible for a weekly cart audit for all residents comparing the eMAR to the medications available on the medication cart. -The RCC was responsible for making sure all new medications were available to administer after a new medication order was written by a resident's provider. Interview with the RCC on 10/23/19 at 4:25pm and 10/24/19 at 12:05pm revealed: -She was responsible for medication order approvals for the eMARs. -Most new medication orders were sent electronically to the pharmacy by the provider but she was responsible for faxing all other orders to the pharmacy. -The MAs were responsible for giving her all the delivery tickets from the pharmacy. -She would make a copy of each new medication order for the Executive Director (ED) and for the MAs. -The MAs were responsible for initialing their copy of each new medication order to show they were aware of the medication change.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 19 -The ED was responsible for auditing all new medication orders weekly compared to the eMAR from the copy of each order she gave to the ED. -She did not review the eMAR for accuracy based on current medication orders once she initially approved the new medication order. -The MAs were responsible for administering medications based on the eMAR. -The MAs were responsible for checking each medication three times against the label before administering a medication to a resident. Interview with the ED on 10/24/19 at 1:10pm revealed: -The RCC was responsible for faxing all new medication orders to the pharmacy and making sure the facility received a copy of all electronically prescribed medication orders. -She or the RCC were responsible for approving medication orders for the eMAR. -The RCC was responsible for making a copy of each new medication order for the MAs and for her so the order could be compared to the eMAR. -She was responsible for auditing each new medication order weekly by comparing the medication order to the eMAR to check for accuracy. -The MAs were responsible for administering medications based on the eMAR.	D 358		
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.	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 20	D912		
	This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to adult care home infection control prevention requirements. The findings are: Based on observations, interviews, and record reviews, the facility failed to implement an infection control policy consistent with the Centers for Disease Control and Prevention guidelines to ensure proper infection control procedures were followed related to 1 medication aide (Staff A) not wearing gloves or following proper disinfection procedures when checking a fingerstick blood sugar and administering insulin [Refer to take 932, GS 131D-4.4A(b) Infection Control Prevention Guidelines (Type B Violation)].		G.S. 131 D-21 (2) Declaration of Residents Rights Community Executive Director and or MCM to review and complete inservice on residents rights with staff. Community inservice on Resident Rights with Regional Ombudsman, Lindsay Tice. ED/MCM to conduct routine interviews with residents to provide time to voice concerns to include continuing following up monthly with Life Enrichment Coordinator on Residents Rights Council meetings and rountine walk-throughs to monitor care and staff interactions with community residents.	 12/10/19 12/18/19 12/06/19
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy	D932	G.S. 131 D- 4.4A (b) Infection Control Prevention Requirements Immediate removal of medication aide until community LHPS nurse provides additional training and skills revalidation Infection Control inservice with all medication aides via ED and or MCM Community LHPS nurse to provide state approved infection control to community staff. Community management ED and or MCM to perform random medication administration observation to monitor infection control prevention twice weekly for thirty days then monthly thereafter.	 10/24/19 10/25/19 11/08/19 11/08/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	Continued From page 21 consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.	D932		

PRINTED: 11/14/2019
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	Continued From page 22	D932		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to implement an infection control policy consistent with the Centers for Disease Control and Prevention guidelines to ensure proper infection control procedures were followed related to 1 medication aide (Staff A) not wearing gloves or following proper disinfection procedures when checking a fingerstick blood sugar and administering insulin.

The findings are:

Observation of medication pass on 10/23/19 from 11:30am to 12:10pm revealed:
-The medication aide (MA) entered Resident #2's room to check his fingerstick blood sugar (FSBS) and to administer insulin.
-The MA carried a small, plastic container labeled with Resident #2's name into the room that contained the supplies to check the FSBS and to administer the insulin.
-The MA did not have gloves in the plastic container she brought into the room and she did not put on gloves prior to checking the FSBS.
-After completing the FSBS, the MA immediately drew up the dose of insulin with a syringe from a multi dose vial.
-The MA did not use an alcohol swab to clean the top of the insulin.
-The MA injected the insulin in Resident #2's abdomen.
-The MA did not clean the injection site on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	Continued From page 23 stomach prior to injecting the insulin. Observation of both medication carts containing residents medication on 10/23/19 at 12:00pm revealed a box of large gloves was available for the staff to use on the top of each medication cart. Observation of the medication pass on 10/23/19 at 12:03pm revealed: -The MA returned to the medication cart after the FSBS and insulin administration. -She documented the FSBS and insulin administration on the eMAR. -She pulled medication cards from the medication cart to administer medications to the next resident. -The MA did not wash her hands or use hand sanitizer until she was stopped and prompted. -The MA removed a 4-ounce bottle of hand sanitizer from the top drawer of the medication cart and sanitized her hands after being prompted. Interview with the medication aide (MA) on 10/23/19 at 12:05pm revealed: -She had worked in assisted living for approximately 14 years. -The gloves on the medication cart were the wrong size and did not fit her hands. -She had a hard time administering insulin and checking FSBS if she wore the wrong size of gloves. -The correct size of gloves was "probably" available in storage, but she did not have time to go check this morning because she was training another medication aide. -She was trained that she needed to wear gloves to check FSBS and to administer insulin. -If she did not have gloves available then she	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	Continued From page 24 would use hand sanitizer. -She knew she was suppose to swab the injection site on Resident #6's abdomen but sometimes he would complain about the alcohol being cold. -She did know she was suppose to swab the vial of insulin before she pulled up the medication in the syringe but just did not do it today. Review of the facility's Infection Control and Standard Precautions Policy revealed: -The facility would provide appropriate personal protective equipment including gloves for staff to wear when exposed to blood or other potentially infection material or contaminated surfaces. -Gloves were to always be worn if staff came in contact with blood, body fluids or other infectious disease material. -Staff was responsible for following guidelines for diabetic testing and care to assure infection control is maintained. Interview with another first shift MA on 10/24/19 at 10:55am revealed: -She always wore gloves when she was "dealing with blood." -She was trained to wear gloves every time she checked a resident's FSBS or gave insulin. -She was trained to clean the top of an insulin vial before drawing up medication and the injection site before administering insulin. -Gloves were always available for the MAs to use during medication administration. Interview with the Resident Care Coordinator (RCC) on 10/24/19 at 12:05pm revealed: -She did not know the MA was not wearing gloves to check a resident's FSBS or administer insulin. -She did not know if the MA did this on a regular basis. -She had not observed a medication pass since	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	Continued From page 25 she started working at the facility about a month ago. -The MAs were responsible for following all facility policies related to infection control. -The MAs were responsible to wear gloves when checking FSBS and swabbing the injection site when administering insulin. -The MAs were responsible for cleaning the top of the multiple dose vial of insulin with an alcohol swab before drawing up medication. -The gloves were important to protect the resident and the MA from the spread of infection. -The MAs were expected to wash their hands after checking FSBS and administering insulin. -The MAs were expected to use hand sanitizer to disinfect their hands a minimum of after every three residents during a medication pass passed on the facility policy. -Gloves and hand sanitizer were always available on the medication carts for the MAs to use when administering medications. -The MAs were expected to clean the site of injection with alcohol before administering medication through injection and cleaning the top of a multi-dose vial. Telephone interview with the facility's contracted Licensed Healthcare Professional Service (LHPS) nurse on 10/24/19 at 3:40pm revealed: -The MAs were taught to always wear gloves to project themselves and the residents from spreading infections when checking FSBS. -The MA knew she was supposed to wear gloves and use alcohol to clean the injection site before administering insulin. -She was responsible for teaching the facility staff infection control procedures and guidelines. -She reviewed basic infection control guidelines, including universal precautions. -The MAs were taught to always wear gloves if	D932		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	Continued From page 26	D932		

Continued From page 26

they had to touch the resident during medication administration, such as during a FSBS check, administering insulin, or eye drops.
-The MAs were taught to always clean the top of a multi-dose vial with an alcohol swab before drawing up the dose and cleaning the injection site before administration.
-Each MA completed the online training when hired.
-She went over the training again during the medication administration skills checkoff.
-She returned to the facility and watched another medication pass by each MA approximately 30 days after hire.
-She returned to the facility to complete the annually required training.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 10/24/19 at 3:05pm revealed:
-It was "never okay" to not wear gloves when working with a resident when blood was involved.
-The MA was responsible for wearing gloves, cleaning the top of the multi-dose vial of insulin, and cleaning the injection site.
-The MA was putting herself and the residents at an increased risk of spreading infections.
-The MA was increasing the risk for contamination of the insulin in the multi-dose vial by not cleaning the top of the insulin vial with alcohol before administration.
-Contaminating the insulin vial put the resident at risk of an infection.

Interview with the Executive Direction (ED) on 10/24/19 at 1:10pm revealed:
-She did not know the MA was not wearing gloves or not taking appropriate steps to disinfect an injection site before administration.
-The MAs were trained to wear gloves during

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060150	A. BUILDING: ______ B. WING ______	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	Continued From page 27	D932		

FSBS and insulin administration.
-The MAs were trained to always was their hands after completing these tasks.
-The facility staff were trained on infection control procedures annually.
-The training was completed online and followed up by an in-service by the LHPS nurse.

The facility failed to implement an infection control policy consistent with the Centers for Disease Control and Prevention for insulin administration and fingerstick blood sugar (FSBS) guidelines to ensure proper infection control procedures were followed resulting in a medication aide not wearing gloves when exposed to blood during a fingerstick blood sugar check and not following disinfection guidelines prior to administering insulin increasing the risk of exposure and spreading blood borne pathogens. This failure to prevent the spread of bloodborne pathogens was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/24/19 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 12, 2019.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.)
- Indicate what measures will be put in place to prevent the problem from occurring again
- Indicate who will monitor the situation to ensure it will not occur again
- Indicate how often the monitoring will take place
- Completion dates by which the plan of correction will be completed. The completion dates must be acceptable to the State.
- Sign and date the bottom of the first page of the State Form.

Return the signed and dated Statement of Deficiencies form within 15 working days from the date of receipt of this letter. We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is SIGNED AND DATED or it will not be accepted. A response to the plan of correction will be sent ONLY if the plan of correction is not accepted. Please retain a copy for your files.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by **December 10, 2019**. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by **December 10, 2019**. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: IDR Coordinator, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at (828) 526-6611. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

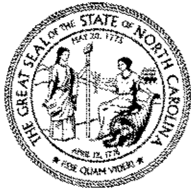
Sincerely,

Renee Howard, PharmD

Renee Howard, PharmD, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosures: Statement of Deficiencies

cc: Mark Rowe, Supervisor/Designee, Mecklenburg County Departement of Social Services
Camille Sherrill, Administrator w/enclosures (included in certified mail # 7018-1830-0002-2908-3554)
Heather Bingham, Team Supervisor, West Team 2 Region, Adult Care Licensure Section
Facility File



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

Certified Mail and Electronic Mail
7018-1830-0002-2908-3554

RECEIVED
DEC 12 2019
ADULT CARE LICENSURE SECTION
RALEIGH

November 15, 2019

Mr. Mel Deaton
Northlake AL Holdings, LLC
Northlake House
PO Box 2568
Hickory, NC 28603

mdeaton@affinitylivinggroup.com

Re: Annual Survey completed October 24, 2019 (ASPEN Event ID: DRV411)
Type B Violation

Facility:	**Northlake House**
Licensure Number:	**HAL-060-150**
County:	**Mecklenburg**

Dear Mr. Deaton:

Thank you for the cooperation and courtesy extended during the survey completed October 24, 2019 by staff with the Adult Care Licensure Section.

Enclosed you will find all violations/deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with the state regulations. You must provide an acceptable Plan of Correction for each violation/deficiency cited in the left column. In the spaces to the right of the form, state your plan for correcting the problem and the completion date by which you will correct each violation/deficiency identified and return it to our office within 15 working days of receipt of this letter. Below you will find what to include in the Plan of Correction for all deficiencies; and, if violations were identified, details of the type of violation(s) and the time frame(s) for compliance are also provided below.

Type B Violation

- Type B rule violation are cited for **G.S. § 131D-4.4A(b) Adult Care Home Infection Prevention Requirements** and **G.S. § 131D-21 Resident Rights.**
- Type B Violation must be corrected within 45 days from the exit date of the survey, which is December 8, 2019.

  As set forth in G.S. § 131D-34 where a facility has failed to correct a Type B Violation, the Department shall assess the facility a civil penalty in the amount of up to $400.00 for each day that the violation continues beyond the time specified for correction.