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
	HAL060158	A. BUILDING: _____ B. WING _____	11/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHARLOTTE ASSISTED LIVING	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 11/19/19 with an exit conference via telephone on 11/20/19.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 6 sampled staff (Staff B and E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: 1. Review of Staff B's personnel record revealed: - Staff B was hired on 06/24/19 as a medication aide (MA). -There was no documentation that a HCPR check had been completed upon hire. Review of a HCPR check for Staff B dated 11/19/19 revealed there were no substantiated findings. Telephone interview with Staff B on 11/19/19 at 5:10pm revealed she did not know what a HCPR check was or if the facility had completed a	D 137	HR Director completed audit of all active employees correcting those employees found missing health care registries. The health care personnel registry is now run on all new hires prior to starting and audited prior to orientation for compliance.	

12-30-19

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Div. — (X6) DATE: 12-30-19
STATE FORM — Laura Ashley Parrish — FV6111 — If continuation sheet 1 of 32

Acknowledged and reviewed 02/10/20 Jeanne S Robinson RN

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	D 137			

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HCPR check upon her hire date.

Refer to the interview with the Business Office Manager (BOM) on 11/19/19 at 3:30pm.

Refer to the interview with the Administrator on 11/19/19 at 4:00pm.

2. Review of Staff E's personnel record revealed:
-Staff E was hired on 10/21/19 as a dietary server.
-There was no documentation that a HCPR check had been completed upon hire.

Review of a HCPR check for Staff E dated 11/19/19 revealed there were no substantiated findings.

Attempted telephone interview with Staff E on 11/19/19 at 4:26pm was unsuccessful.

Refer to the interview with the Business Office Manager on 11/19/19 at 3:30pm.

Refer to the interview with the Administrator on 11/19/19 at 4:00pm.

_____

Interview with the Business Office Manager (BOM) on 11/19/19 at 3:30pm revealed: -
She was hired in July 2019 as the Business Office Manager.
-She was responsible for ensuring the staff had all HCPR checks.
-The Administrator informed her that all staff were required to have HCPR checks completed upon hire after an audit of staff records were completed last week.
-She was off for two days and had not had time to complete the HCPR checks for the new hired staff.

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D 137	Continued From page 2 Interview with the Administrator on 11/19/19 at 4:00pm revealed: -The BOM was responsible for ensuring staff had HCPR checks. -She knew that all staff were required to have HCPR checks completed upon hire. -She conducted an audit of the staff records last week and realized the BOM had not completed HCPR checks for a few new hired staff. -She informed the BOM to complete the HCPR last week for the new hired staff. -The BOM was off for a few days after the audit and just overlooked the HCPR checks or had not time to run the HCPR checks.	D 137		
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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up with the licensed practitioner for 2 of 3 sampled residents (Residents #1 and #3) related to a physical therapy referral and notification of	D 273		

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D 273	Continued From page 3 combative behaviors (Resident #3), and a resident regarding referrals of medications used to treat heart failure and glaucoma (Resident #1). The findings are: 1. Review of Resident #3's current FL2 dated 08/27/19 revealed diagnoses included Alzheimer's dementia, bradycardia, stage 3 chronic kidney disease, and diabetes. a. Review of a signed physician's order for Resident #3 dated 09/10/19 revealed an order for physical and occupational therapy to treat and evaluate. Review of Resident #3's record revealed there was no documentation Resident #3 had been evaluated for physical or occupational therapy. Review of the facility's home health communication binder on 11/19/19 revealed there was no documentation Resident #3 had been evaluated by a physical or occupational therapist. Review of Resident #3's progress notes revealed from 10/14/19 through 11/18/19 there were six unwitnessed falls. Interview with the Director of the facility's contracted physical and occupational therapy provider on 11/19/19 at 11:50am revealed: -She received referrals via email from the Resident Care Director (RCD) and the Resident Care Coordinator (RCC). -She was not able to complete an initial assessment or evaluation until a "hard copy" order with the physician's actual signature was received. -The Responsible Party (RP) and the Power of	D 273	Staff educated on referral/follow up process with therapy evaluations and treatment orders on beginning within 72hrs post evaluation. Tracking will occur on new order tracking form monitored by RCC/RCD daily. If order not started after 72hrs, will notify PCP for direction.	11/22/2019 11/29/2019

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D 273	Continued From page 4 Attorney (POA) would also be responsible for providing consent to begin services after the referral was received. -If the consent was not received, she would notify the RCD, RCC, or the Administrator of pending paperwork. -She received an email from the previous RCD for physical and occupational therapy referral for Resident #3 on 09/13/19. -She was told by another contracted home health provider that Resident #3 was currently still receiving physical and occupational services and he would not be discharged until 09/31/19. -She would have needed a new order on 10/01/19 to begin services, however it was not received. -She informed the management team (RCD, RCC, and Administrator) during the monthly meeting in October 2019, that she had not evaluated Resident #3 and asked if he still needed to be evaluated. -She had not requested a new order for physical or occupational therapy evaluation. -She thought Resident #3 still needed to be evaluated, however she was still pending consents and insurance information from the POA. -She and the facility management staff reached out to the POA and the consent was received on 11/12/19. -If consents were received timely and she had a current order, the therapists would have been able to begin physical and occupational services. -The RCD or RCC would be responsible for getting the order and consent. -As of 11/19/19, Resident #3 had not been evaluated for physical or occupational services. -Physical and occupational services could assist with conditioning and preventing falls.	D 273		

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Telephone interview with the other home health provider on 11/19/19 at 4:45pm revealed: -Resident #3 did not have a current order to receive physical or occupational therapy services.
-Resident #3 had not received physical or occupational services since 04/30/19, he was discharged as goals were met.

Interview with Resident #3's Primary Care Provider (PCP) on 11/19/19 at 3:20pm revealed: -She was new to the facility and 11/19/19 was her first day as the medical provider for the facility. -She was able to review notes from the previous provider and she was notified that Resident #3 had falls.
-The previous PCP ordered physical and occupational therapy for Resident #3 on 09/10/19.
-She had not seen any notification received from the facility that therapy services had not begun as ordered until 11/13/19.
-She informed the RCC on 11/13/19, that the resident would need to be seen face-to-face for another order to be written for physical and occupational therapy.
-She would have expected the facility to notify her of any orders that were not carried out. -She thought physical or occupational therapy could have helped to prevent falls for Resident #3.
-She wrote another order on 11/19/19 for physical and occupational therapy to treat and evaluate Resident #3.

Review of an order for Resident #3 dated 11/19/19 revealed an order from the home health physical and occupational therapy to treat and evaluate with history of falls; resident with Alzheimer's dementia.

Interview with a medication aide (MA) on 11/19/19

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at 4:00pm revealed:
-Resident #3 had a history of falls.
-MAs were responsible for documenting falls in the progress notes when they occurred. -MAs were not responsible for processing any treatment or medication orders.
-The RCD and RCC were responsible for following up on orders and notifying the physician.
-The MAs had no verbal or electronic contact with the physicians.
-She did not know if Resident #3 had received physical or occupational therapy

Interview with the RCC on 11/19/19 at 2:35pm revealed:
-She was responsible for processing and following-up on physician's orders for the residents.
-She became responsible for processing and following-up after the previous RCD resigned. -The previous RCD left "a few weeks ago" and she was responsible for following up with all treatment orders for physical and occupational therapy.
-She did not realize Resident #3's therapy order was never followed-up until 11/13/19 after Resident #3 had a fall.
-She reached out to the PCP on 11/13/19 to get an updated order and was told a face-to-face assessment would need to be completed. -She knew that a consent was pending from the POA, however she did not realize the therapy had not begun.
-After the RCD left, she was responsible for following-up with the physician for a new order, however she did not know a new order was needed until reaching out to physical therapy on 11/13/19.

Interview with the Administrator on 11/19/19 at

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D 273	Continued From page 7 3:47pm revealed: -Physical and occupational therapy referrals were sent to the in-house therapy provider, located on the 2nd floor of the facility. -The therapy provider was responsible for following up with family to get the initial consent and insurance paperwork completed by the family. -The Therapy Director would let her or the RCD know if there were issues getting services started due to a pending consent. -She knew Resident #3's POA was delayed in getting paperwork, however did not know the physician was not notified about the delay and the therapy was not started. -The previous RCD was not completing follow-up with the physician. -She and the RCC were now responsible for following up with the physician and the family to ensure services were initiated. -She followed up with the resident's daughter twice and received no response; she was unable to provide the dates in which follow-up occurred. -She did not realize the first follow-up with the physician for physical and occupational therapy was on 11/13/19. -She would expect the RCC and RCD to follow-up with the physician if the services would not be able to begin in a timely manner. Based on interviews, observations, and record reviews it was determined Resident #3 was not interviewable. Attempted interview with Resident #3's POA on 11/19/19 at 11:34am was unsuccessful. b. Review of Resident #3's progress notes revealed: -There was a note dated 09/14/19 at 7:46am; the	D 273		

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resident was "combative and refusing care" bed and brief soiled, resident stated, "he wants to die" "leave him alone", resident was shaking "really bad" and refused snacks and drinks.
-There was a note dated 09/15/19 at 4:26am; the resident became "combative" when staff went to assist with changing brief, he started to kick his legs around and told staff to leave him alone. -
There was a note dated 09/17/19 at 5:08am; the resident was observed at his room door at 4:00am confused about his location, he was "agitated" and became combative with staff. -
There was not note dated 09/18/19 at 6:47am; the resident was "combative" and was not able to understand that he needed care for a wet brief, bedding, and clothes, "not able to reason with member[sic]'.
-There was a note on 10/05/19 at 1:00pm; the resident was "very aggressive and confused", he did not eat or take any medication.
-There was a note dated 11/07/19 at 11:02am; the resident stated that "he would kill trainer[sic]" and was refusing to put shoes on.
-There was a note dated 11/08/19 at 6:42am; the resident was "very combative", the resident barricaded the door with his hamper to prevent staff from coming into the room.
-There was a note dated 11/10/19 at 6:41am; the resident became agitated and started to kick his legs at staff when trying to assist with a brief change, 3 staff members attempted to change resident with no result.
-There was no documentation Resident #3's primary care provider (PCP) was contacted about any of the documented episodes of combativeness and refusal of care.

Interview with Resident #3's PCP on 11/19/19 at 3:20pm revealed:
-She was new to the facility and 11/19/19 was her

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D 273	Continued From page 9 first day as the medical provider for the facility. - She was able to review notes from the previous provider and was unable to find any documentation of notification that Resident #3 was displaying combative and agitated behaviors. -The previous PCP had not ordered any mental health services for Resident #3. -If a resident was presenting with combative behaviors, she would have expected the facility to notify her so that the resident could be evaluated by mental health. -The PCP did not normally order anti-anxiety medications, the mental health provider would be responsible for mental health medications. -She would have expected the facility to notify her of any changes in condition or to request a mental health referral. -She wrote an order on 11/19/19 for mental health to evaluate Resident #3. Review of Resident #3's record revealed there was no notification to the physician regaring combative behaviors, referral for mental health, no progress notes from mental health services, and no request for an order for mental health services. Review of Resident #3's medication orders and September, October, and November 2019 electronic Medication Administration Records (eMARs) revealed there were no anti-anxiety medication ordered to treat resident for agitation. Review of an order for Resident #3 dated 11/19/19 revealed an order for a mental health consent to be obtained from the Power of Attorney (POA) to address behaviors if family was in agreement. Interview with a medication aide (MA) on 11/19/19	D 273		

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at 4:00pm revealed:
-MAs were responsible for documenting change of condition and behaviors in the resident's progress notes when they occurred.
-MAs were not responsible for processing any treatment or medication orders.
-The Resident Care Director (RCD) and Resident Care Coordinator (RCC) were responsible for following up on orders and notifying the physician if there were any changes.
-The RCD and RCC were notified of changes with resident by reviewing progress notes.
-The MAs had no verbal or electronic contact with the physicians.

Interview with the RCC on 11/19/19 at 2:35pm revealed:
-She was responsible for processing and following-up on physician's orders for the residents.
-The previous RCD left "a few weeks ago" and she was responsible for following up with all treatment orders.
-If a resident had frequent combative behaviors, she was to notify the PCP for a referral to the mental health provider.
-She did not realize Resident #3 had frequent documentation of combative and agitated behaviors.
-She was responsible for reviewing progress notes to identify changes with residents. -
She tried to review the progress notes in the electronic record weekly.
-She had not reached out to the PCP to notify of the behaviors or obtain an order for mental health.
-After the previous RCD left, she was responsible for following-up with the physician with changes and requesting new orders, however she did not know an order was needed for mental health

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D 273	Continued From page 11 services for Resident #3. Interview with the Administrator on 11/19/19 at 3:47pm revealed: -The MAs were responsible for notifying the RCC of any changes in behaviors. -MAs could notify the RCC verbally and by documenting in the resident's progress notes of any changes. -The MAs were not responsible for contacting the physician. -She expected the RCC to be reviewing progress notes and following-up with the physician when need for additional orders. -The RCC or RCD was responsible for notifying the physician and getting intructions for interventions after 3 documented combative or aggressive behaviors. -She did not know Resident #3 had frequent combative behaviors. -The previous RCD was responsible for initial follow-up; however it was not completed. -She and the RCC were now responsible for following up with the physician and the family to ensure mental health services were initiated. Based on interviews, observations, and record reviews it was determined Resident #3 was not interviewable. Attempted interview with Resident #3's POA on 11/19/19 at 11:34am was unsuccessful. 2. Review of Resident #1's current FL2 dated 01/31/19 revealed diagnoses included chronic diastolic heart failure, non-healing lower leg wounds, aortic stenosis and hypertension. a. Review of Resident #1's current FL2 dated 01/31/19 revealed there was an order for Furosemide 20mg, (a medication used to treat	D 273	RCC/RCD and ED will monitor 24 hour report daily for behaviors and trend on weekly basis on each member for those displaying trend of aggression or combative behaviors. Those with trend of 3 or more incidents in a month time frame will have PCP notified. Staff also educated on definition of combative and aggressive behaviors for proper documenting.	11/29/2019

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D 273	Continued From page 12 fluid build up), to be administered daily. Review of Resident #1's Care Plan dated 07/31/19, signed by the provider, revealed an order for Furosemide 20mg one tablet daily. Review of Resident #1's September 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Furosemide 20 mg tablet, to be administered daily at 9:00am. -Furosemide 20 mg was not documented as administered from 09/01/19 through 09/11/19. -Resident #1 was not administered Furosemide 20mg 11 out of 30 possible opportunities. -There was no documentation the primary care provider (PCP) was notified regarding the missed doses of Furosemide. -There was no documented reason provided for the missed doses of Furosemide. Review of Resident #1's October 2019 eMAR revealed: -There was an entry for Furosemide 20 mg tablet, to be administered daily at 9:00am. -Furosemide 20mg was not documented as administered on 10/04/19 and 10/15/19. -Furosemide 20mg was not documented as administered on 10/22/19 through 10/25/19 and 10/28/19 through 10/31/19. -Resident #1 was not administered Furosemide 20mg 9 out of 31 possible opportunities. -There was no documentation the PCP was notified regarding the missed doses of Furosemide. -There was no documented reason provided for the missed doses of Furosemide. Review of Resident #1's November 2019 eMAR revealed:	D 273		

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(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 -There was an entry for Furosemide 20 mg tablet, to be administered daily at 9:00am. -Furosemide 20mg was not documented as administered from 11/01/19 through 11/03/19 and 11/11/19 through 11/19/19. -Resident #1 was not administered Furosemide 20mg 12 out of 19 possible opportunities. - There was no documentation the PCP was notified regarding the missed doses of Furosemide. -There was no documented reason provided for the missed doses of Furosemide. Interview with the first shift medication aide (MA) on 11/19/19 at 11:45am revealed: -She worked first shift and administered Resident #1's medications. -Resident #1 refused her Furosemide frequently due to increased urination. -She had informed the previous Resident Care Director (RCD) Resident #1 was refusing her scheduled Furosemide. -She also reported the refusals to the Resident Care Coordinator (RCC). -The MA brought the bottle of Furosemide 20mg to the RCC a few days ago since the RCC was going to request a discontinue order from the physician. -She had not notified Resident #1's physician regarding the refusals; she thought the RCD or the RCC would contact the physician. -The MAs could contact the physician, but usually the RCD or the RCC would. -She thought it was the facility's policy to contact the physician after a resident refused a medication "3 or 4 times". A policy for resident's refusals of medications was not provided.	D 273	Staff to be educated on EMAR system with properly clincking into the note section for reason meds not given. Report will be run by RCC/RCD weekly to review medications not given and follow up on documentation. PCP will be notified after 3 missed doses.	12/20/2019

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D 273	Continued From page 14 Interview with the facility's contracted pharmacist on 11/19/19 at 12:46pm revealed: -Resident #1's medications were were put into their system for the record as "profile only"-the contracted pharmacy did not fill Resident #1's medication prescriptions. -Resident #1 received her medications from a mail order pharmacy. -Furosemide 20mg daily was an active order on Resident #1's medication profile. Observation of medications on hand on 11/19/19 at 8:00am revealed: -Furosemide 20 mg was not on the medication cart at the time of the medication pass. -The MA brought the bottle of Furosemide from the RCC's office to offer to administer to Resident #1. Interview with Resident #1 on 11/19/19 at 2:30pm revealed: -She received her medications from a mail order pharmacy due to cost effectiveness. -The MAs informed her when she needed to re-order medications and she contacted the pharmacy. -She had some open areas on her lower legs treated by home health but they were healed at this time. -She refused her Furosemide when she was leaving the facility for an outing due to urinary frequency. -She had not mentioned this to her physician. -She did not know if the MAs had informed her primary care physician (PCP). Interview with the RCC on 11/19/19 at 10:22am revealed: -If a resident refused medications 3 days consecutively, she or the MAs should inform the	D 273	New order tracking form implemented for staff to use. Form shows tracking on when new order received, sent to pharmacy, and when medications are implemented. RCC/RCD will review daily and follow up as needed. PCP will be notified after 24hrs of medication not in house.	12/2/2019

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D 273	Continued From page 15 PCP. -She did not run a report for missed medications, and was not sure if there was an option for that function on the software. -The previous Resident Care Director may have reviewed the eMARs and run a missed medications report. -Resident #1 had an active order for Furosemide 20mg daily. -Resident #1 had trouble with lower leg edema, causing skin breakdown on her legs at times. -She did not know Resident #1 had missed Furosemide 20mg 11 consecutive days in September 2019, 4 consecutive days in October 2019 and 8 consecutive days in November 2019, with no documentation the PCP was notified. -She did know there were some refusals and she was going to request an order from the primary care physician (PCP) to discontinue the medication. -The PCP was scheduled for their routine visit on 11/20/19. -It was her expectation refused medications would be documented and the resident's physician notified for further instructions by the MA. Interview with the Administrator on 11/19/19 at 4:05pm revealed: -The current RCC was new and had been performing the duties of the RCD and RCC while they were hiring for the RCD position. -It was her expectation the MAs would report to the RCC when there were 3 or more refused medications and the RCC or MA would contact the primary care physician. -It would have been the responsibility of the previous RCD to review the eMAR and any missed medications and notify the physician for further instructions.	D 273		

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D 273	Continued From page 16 -She did not know how often the previous RCD was reviewing the eMARs. -She did not know Resident #1 had refused 11 consecutive doses in September 2019, 4 consecutive doses in October 2019 and 8 consecutive doses in November 2019 of Furosemide 20mg, and there was no documentation the physician was notified. Attempted interview with Resident #1's Power of Attorney on 11/19/19 at 12:40pm was unsuccessful. Attempted telephone interview with Resident #1's PCP on 11/19/19 at 3:40pm was unsuccessful. b. Review of Resident #1's current FL2 dated 01/31/19 revealed an order for Azopt 1% eye drops, used to treat increased eye pressure, three times a day. Review of Resident #1's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Azopt 1% eye drops, to be administered three times daily at 8:00am, 12:00pm and 4:00pm. -Azopt eye drops was not documented as administered from 10/01/19 through 10/04/19 at 8:00am, 12:00pm or 4:00pm -There was no documentation the prescribing physician was notified regarding the missed doses of Azopt eye drops on 10/01/19 through 10/04/19. -There was no documentation as to the reason the eye drops were not administered on 10/01/19 through 10/04/19. Interview with the first shift medication aide (MA) on 11/19/19 at 11:45am revealed:	D 273		

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D 273	Continued From page 17 -She administered Resident #1's Azopt eye drops at 8:00am and 12:00pm. -She did not remember the Azopt eye drops not being available for administration from 10/01/19 through 10/04/19. -She did not notify the physician Resident #1 missed the Azopt eye drops for 4 consecutive days. -She thought the Resident Care Coordinator (RCC) notified the physician regarding missed medications. Interview with the second shift MA on 11/19/19 at 4:25pm revealed: -She worked second shift and administered Resident #1's eye drops at 4:00pm. -She did not know why the eye drops were not documented as administered from 10/01/19 through 10/04/19. -She did not remember a time when the eye drops were not available for administration. -She did not remember notifying Resident #1's prescribing physician of the missed medication. Interview with the Resident Care Coordinator (RCC) on 11/19/19 at 10:22am revealed: -She did not know Resident #1 had missed her Azopt eye drops from 10/01/19 through 10/04/19, three times daily. -She would have expected the MAs to notify the prescribing physician that Resident #1 had missed the eye drops. Interview with Resident #1 on 11/19/19 at 2:30pm revealed: -She usually received her medications daily and on time. -She was diagnosed with glaucoma and was prescribed Azopt eye drops three times a day to prevent increased eye pressure.	D 273		

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D 273	Continued From page 18 -She knew how important these drops were to her eye health. -She did not always receive her eye drops three times a day, especially the 12:00pm dose. -She had not told the RCC or Administrator;"I don't like to cause a fuss." -She did not remember if the Azopt eye drops were not administered from 10/01/19 through 10/04/19. Interview with the Administrator on 11/19/19 at 4:05pm revealed: -In the absence of the RCC and RCD, the MAs should notify the physician if a resident missed medications 3 or more consecutive days. -She did not know Resident #1 had missed the administration of her Azopt eye drops for 4 consecutive days. -She did not know the prescribing physician had not been notified of the missed eye drops. -Resident #1 had not informed her she missed her 12:00pm administration of Azopt eye drops at times. Attempted interview with Resident #1's Power of Attorney on 11/20/19 at 12:40pm was unsuccessful. Attempted telephone interview with Resident #1's prescribing physician on 11/20/19 at 12:15pm was unsuccessful. --- The facility failed to coordinate and assure referral and follow up with the primary care provider for Resident #3 regarding a referral for physical and occupational therapy for two months which could have helped to prevent the six falls which occurred during this time period and failed to notify the physician of aggressive and combative behaviors resulting in the resident not	D 273		

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D 273	Continued From page 19 receiving mental health services or treatment for behaviors. The facility failed to notify Resident #1's PCP of refusals of a fluid medication for a diagnosis of heart failure and chronic lower leg edema over a period of 3 months. The facility's failure was detrimental to the health, safety and welfare of Residents #1 and #3 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/19/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 7, 2020.	D 273		
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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (Residents #4 and #2) related to a medication for heart failure (Resident #4) observed during the 8:00am medication pass on 11/19/19 and 1 of 3 sampled residents for record review (Resident #2) including errors with a medication used to	D 358		

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D 358	Continued From page 20 treat high blood pressure and heart failure. The findings are: The medication error rate was 9% as evidenced by the observation of 3 errors out of 34 opportunities during the 8:00am medication pass on 11/19/19. 1. Review of Resident #4's current FL2 dated 07/02/19 revealed: -Diagnoses included dementia, heart failure and hypertension -There was an order for Carvedilol (used to treat heart failure) 12.5mg, one half tablet to be administered twice a day Observation of the 9:00am medication pass in the Special Care Unit (SCU) on 11/19/19 at 9:23am revealed: -The medication aide (MA) pulled 8 medications for Resident #4, excluding Carvedilol, from the medication cart. -Each medication was verified and punched into a medication cup one at a time. -There were 8 tablets in the medication cup. -Carvedilol was not in the medication cup. -The MA added applesauce to the medications and administered them to Resident #4 at 9:29am. Review of Resident #4's November 2019 electronic Medication Administration Record (eMAR) revealed there was an entry for Carvedilol 12.5mg, administer one half tablet (6.25mg) twice a day at 9:00am and 7:00pm. Observation of Resident #4's medications on hand revealed there were no Carvedilol 6.25mg tablets available for administration.	D 358		

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D 358	Continued From page 21 Interview with the medication aide (MA) on 11/19/19 at 9:40am revealed: -Resident #4 was on cycle fill medications from the pharmacy. -Cycle fill medications were delivered in a batch on a monthly basis. -She did not know when the next cycle fill of medications was due at the facility. -Carvedilol was not available for administration to Resident #4 on 11/19/19. -She did not know why the Carvedilol had not been requested for refill before this morning's medication pass by the previous MAs. -She would notify the Resident Care Coordinator (RCC) after the medication pass was completed and the RCC would contact the pharmacy. -The MAs were to submit a request for medication refills when needed to the RCC and she would send the request to the pharmacy. Interview with the second shift MA on 11/19/19 at 3:12pm revealed: -She knew Resident #4 was out of Carvedilol. -She left a list of medications that needed to be refilled on the RCC's desk yesterday (11/18/19). -The RCC ordered all the resident's medications in between cycle fill if needed. Interview with another MA on 11/19/19 at 3:20pm revealed: -She was on duty on first shift on Saturday 11/16/19. -She contacted the pharmacy to refill Resident #4's Carvedilol 6.25mg since there were only 2 doses left in the blister pack and no additional medication in the RCC's office. -She also worked the first shift Sunday, 11/17/19 and administered the last Carvedilol at 9:00am. -She had not worked since 11/17/19 and did not know the Carvedilol had not been delivered by	D 358		

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D 358	Continued From page 22 the pharmacy to the facility. -She did not notify the RCC since she contacted the pharmacy directly for a refill of Carvedilol. Interview with the Resident Care Coordinator (RCC) on 11/19/19 at 10:22am revealed: -The facility had recently changed over to a cycle fill schedule for delivery of medications. -The last cycle fill date for medications to arrive was on 10/29/19. -On 11/01/19 was the date the medications were stocked on the medication carts. -A pharmacist from the facility's contracted pharmacy, would arrive at the facility every month after the medications were delivered. -The pharmacist checked the medications in the tote each month to verify every resident had received the correct medications in the correct dosage. -After the pharmacist reviewed the medications, the facility staff stocked the medication carts. -This pharmacy review each month was the current process in place for medication cart audits. -Additional audits could be implemented by the RCC as needed. -She knew Resident #4 was out of Carvedilol. -She had faxed the medication order form to the pharmacy yesterday, 11/18/19, requesting a refill of Carvedilol 6.25mg. -She did not know why the pharmacy had not sent the medication last night in the tote. -She would place another call to the pharmacy to follow up regarding Carvedilol. -She expected the MAs to complete a medication re-order form and submit it to her before the medication was finished. -She would expect the medication to be ordered 3-5 days before completion. -She expected the MAs to inform her within that	D 358		

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D 358	Continued From page 23 time frame so the medication was in the facility when the last tablet was administered. -She did not know the first shift MA had administered the last Carvedilol tablet on 11/17/19 at 9:00am. -She did not know the MA contacted the pharmacy on 11/16/19 and requested a refill for Carvedilol tablets. Interview with the Administrator on 11/19/19 at 4:05pm revealed: -She did not know Resident #4 was out of Carvedilol. -The facility's contracted pharmacy staff reviewed all the medications sent from the pharmacy on the cycle fill date before the facility staff stocked the medication carts. -She did not know why Resident #4 would have finished the blister pack of Carvedilol before the next cycle fill date (12/01/19). -The facility had just begun a cycle fill rotation for medication delivery and there were still some "bumps to iron out" (facility staff and pharmacy staff communication and processes). -She expected the MAs to notify the RCC when the blister packs had about 5 or less doses remaining. -If a medication had been ordered and was not on the medication cart, the MA should notify the RCC. -The RCC should follow up with the pharmacy. -The prescribing physician should be notified of any missed medications and any additional orders should be implemented. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Attempted telephone interview with Resident #4's	D 358		

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D 358	Continued From page 24 PCP on 11/19/19 at 3:40pm was unsuccessful. 2. Review of Resident #2's current FL2 dated 08/16/19 revealed diagnoses included Alzheimer, heart disease, congestive heart failure and chronic kidney disease. a. Review of Resident #2's current FL2 dated 08/16/19 revealed medication orders included bumetanide (a diuretic used to treat high blood pressure) 0.5mg daily hold for systolic blood pressure (B/P) less than 120. Review of Resident #2's September 2019 electronic medication administration record (eMAR) revealed: -There was an entry for bumetanide 0.5mg daily scheduled at 8:00am with perimeters to "hold for systolic blood pressure less than 120." -There was documentation on 09/07/19 Resident #2's B/P was 116/74 and bumetanide 0.5mg was administered. -There was documentation on 09/08/19 Resident #2's B/P was 111/41 and bumetanide 0.5mg was administered. -There was documentation on 09/17/19 Resident #2's B/P was 111/82 and bumetanide 0.5mg was administered. -There was documentation on 09/30/19 Resident #2's B/P was 114/89 and bumetanide 0.5mg was administered. Review of Resident #2's October 2019 eMAR revealed: -There was an entry for bumetanide 0.5mg daily at 8:00am with perimeters to "hold for systolic blood pressure less than 120." -There was documentation on 10/05/19 Resident #2's B/P was 88/56 and bumetanide 0.5mg was administered.	D 358		

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D 358	Continued From page 25 -There was documentation on 10/13/19 Resident #2's B/P was 105/51 and bumetanide 0.5mg was administered. -There was documentation on 10/24/19 Resident #2's B/P was 109/60 and bumetanide 0.5mg was administered. -There was documentation on 10/26/19 Resident #2's B/P was 118/60 and bumetanide 0.5mg was administered. -There was documentation on 10/27/19 Resident #2's B/P was 118/60 and bumetanide 0.5mg was administered. Review of Resident #2's November 2019 eMAR from 11/01/19 to 11/19/19 revealed: -There was an entry for bumetanide 0.5mg daily at 8:00am with perimeters to "hold for systolic blood pressure less than 120." -There was documentation on 11/06/19 Resident #2's B/P was 115/63 and bumetanide 0.5mg was administered. Observation of Resident #2's medications on hand on 11/19/19 at 11:18pm revealed: -There was a bubble pack labeled bumetanide 0.5mg to be administered daily with perimeters to hold for systolic blood pressure less than 120. -There were 12 tablets left in the bubble pack. Interview with the medication aide (MA) on 11/19/19 at 2:49pm revealed: -She compared the medications to the eMAR verifying those orders with the label on the medication bubble pack. -She always checked both the eMAR order and the medication label. -She knew Resident #2 had B/P perimeters for bumetanide 0.5mg. -She had administered bumetanide 0.5mg to Resident #2 12 times in September 2019, 2 times	D 358		

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(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 being administered outside of perimeters on 09/17/19 and on 09/30/19. -She had administered bumetanide 0.5mg to Resident #2 16 times in October 2019, 4 times being administered outside of perimeters on 10/05/19, 10/24/19, 10/26/19 and on 10/27/19. -She had administered bumetanide 0.5mg to Resident #2 13 times in November 2019, 1 times being administered outside of perimeters on 11/06/19. Based on observations, interviews and record reviews it was determined Resident #2 was not interview. Telephone interview with Resident #2's Primary Care Provider's nurse on 11/19/19 at 3:27pm revealed: -Resident #2 had a history of heart disease and high blood pressure. -The bumetanide was used for high blood pressure. -If the MAs administered bumetanide with a low B/P the medications could lower the B/P which could cause complications of dizziness and confusion. -She had not noticed any complications for Resident #2 B/P, or had Resident #2 been in the hospital for any issues regarding his B/P. Interview with the Resident Care Coordinator (RCC) on 11/19/19 at 3:47pm revealed: -The medication administration policy required the MAs to read the eMAR order for each medication and verify the label on the medication matched the order on the eMAR. -The MAs were responsible for obtaining B/P prior to administering medications with perimeters. -She did not know the MAs administered	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060158	A. BUILDING: _____ B. WING _____	11/20/2019

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D 358	Continued From page 27 Resident #2's bumetanide 0.5mg when his systolic B/P was less than 120. -The Resident Care Director (RCD) was responsible for monthly audit of the eMARs but that position was vacant. -She was filling in for the RCD but had not reviewed the eMAR's for completion, holes, or incorrect administration. Interview with the Administrator on 11/191/9 at 4:00pm revealed: -She relied on the RCC and the MAs to follow the process and procedures for correct medication administration. -The MAs should be referring to the directions on the medication label and the eMAR before administering medications or holding medications. -She did not know the MA had administered Resident #2's bumetanide 0.5mg when his systolic B/P was less than 120. -The RCC was responsible for completing monthly audits of the eMARs. b. Review of Resident #2's current FL2 dated 08/16/19 revealed medication orders included Carvedilol (used to treat high blood pressure) 6.25mg two times daily hold for systolic blood pressure (B/P) less than 120. Review of Resident #2's September 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Carvedilol 6.25mg scheduled at 8:00am and 5:00pm with perimeters to hold for systolic blood pressure less than 120. -There was documentation on 09/08/19 at 8:00am Resident #2's B/P was 111/41 and Carvedilol 6.25mg was administered. -There was documentation on 09/17/19 at	D 358	RCC/RCD will monitor MARS monthly that includes a weekly cart audit done by SIC or MA's, MAR checks for no missed medications, no expired or discontinued medications, and cart sanitation. MA's to be trained on EMAR system to include parameters, administration notes, and proper documentation.	12/31/2019 12/26/2019

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D 358	Continued From page 28 8:00am Resident #2's B/P was 111/82 and Carvedilol 6.25mg was administered. -There was documentation on 09/30/19 at 8:00am Resident #2's B/P was 114/49 and Carvedilol 6.25mg was administered. Review of Resident #2's October 2019 eMAR revealed: -There was an entry for Carvedilol 6.25mg scheduled at 8:00am and 5:00pm with perimeters to hold for systolic blood pressure less than 120. -There was documentation on 10/05/19 at 8:00am Resident #2's B/P was 88/56 and Carvedilol 6.25mg was administered. -There was documentation on 10/13/19 at 8:00am Resident #2's B/P was 105/51 and Carvedilol 6.25mg was administered. -There was documentation on 10/24/19 at 8:00am Resident #2's B/P was 109/60 and Carvedilol 6.25mg was administered. -There was documentation on 10/26/19 at 8:00am Resident #2's B/P was 118/60 and Carvedilol 6.25mg was administered. -There was documentation on 10/27/19 at 8:00am Resident #2's B/P was 118/60 and Carvedilol 6.25mg was administered. Review of Resident #2's November 2019 eMAR from 11/01/19 to 11/19/19 revealed: -There was an entry for Carvedilol 6.25mg scheduled at 8:00am and 5:00pm with perimeters to hold for systolic blood pressure less than 120. -There was documentation on 11/02/19 at 5:00pm Resident #2's B/P was 110/62 and Carvedilol 6.25mg was administered. -There was documentation on 11/06/19 at 8:00am Resident #2's B/P was 115/63 and Carvedilol 6.25mg was administered. Observation of Resident #2's medications on	D 358		

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D 358		D 358		

Continued From page 29

hand on 11/19/19 at 11:18pm revealed: -There was a bubble pack labeled Carvedilol 6.25mg to be administered two times daily with perimeters to hold for systolic blood pressure less than 120. -There were 19 pills left in the bubble pack.

Interview with the medication aide (MA) on 11/19/19 at 2:49pm revealed:
-She compared the medications to eMAR verifying those orders with the label on the medication bubble pack.
-She always checked both the eMAR order and the medication label.
-She knew Resident #2 had B/P perimeters for Carvedilol 6.25mg.
-She had administered Carvedilol 6.25mg to Resident #2 12 times in September 2019, 3 times being administered outside of perimeters on 09/08/19, 09/17/19 and on 09/30/19.
-She had administered Carvedilol 6.25mg to Resident #2 16 times in October 2019, 4 times being administered outside of perimeters on 10/05/19, 10/24/19, 10/26/19 and on 10/27/19.
-She had administered Carvedilol 6.25mg to Resident #2 13 times in November 2019, 1 times being administered outside of perimeters on 11/06/19.

Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable.

Telephone interview with Resident #2's Primary Care Provider's nurse on 11/19/19 at 3:27pm revealed:
-Resident #2 had a history of heart disease and high blood pressure.
-The Carvedilol was used for high blood pressure.
-If the MAs administed the Carvedilol with a low

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D 358	Continued From page 30 B/P the medications could lower the B/P which could cause complications of dizziness and confusion. -She had not noticed any complications for Resident #2 B/P, or had Resident #2 been in the hospital for any issues regarding his B/P. Interview with the Resident Care Coordinator (RCC) on 11/19/19 at 3:47pm revealed: -The medication administration policy required the MAs to read the eMAR order for each medication and verify the label on the medication matched the order on the eMAR. -The MAs were responsible for obtaining B/P prior to administering medications with perimeters. -She did not know the MAs administered Resident #2's Carvedilol 6.25mg when his systolic B/P was less than 120. -The Resident Care Director (RCD) was responsible for monthly audit of the eMARs but that position was vacant. -She was filling in for the RCD but had not reviewed the eMARs for completion, holes, or incorrect administration. Interview with the Administrator on 11/191/9 at 4:00pm revealed: -She relied on the RCC and the MAs to follow the process and procedures for correct medication administration. -The MAs should be referring to the directions on the medication label and the eMAR before administering medications or holding medications. -She did not know the MA had administered Resident #2's Carvedilol 6.25mg when his systolic B/P was less than 120. -The RCC was responsible for completing monthly audits of the eMARs.	D 358		

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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. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up with the licensed practitioner for 2 of 3 sampled residents (Residents #1 and #3) related to a physical therapy referral and notification of combative behaviors (Resident #3), and Resident #1 regarding referrals of medications used to treat heart failure and glaucoma. [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912	See POC notes on page 5 and 13.	