East Towne Assisted Living 4815 N Sharon Amity Road Charlotte, NC 28205 P:704-531-0948 F: 704-531-6009 Email:<u>Estn.adm@algsenior.com</u>

August 25,2020

Attached is the plan of correction in reference to the Statement of Deficiencies for East Towne Assisted Living, regarding the death complaint survey. Which was completed on 7/15/2020.Please feel free to contact me at the number or email listed above.

Thank you,

Marsha Repe

Marsha Pope, Executive Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SI COMPLE	
	HAL060149	B. WING	TOTISTIC IN BRANK WARMANNEL	07/15	1 2 020
NAME OF PROVIDER OR SUPPLIER	4815 NOR		STATE, ZIP CODE N AMITY ROAD 205	<u>Y * * * * * * * * * * * * * * * * * * *</u>	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
Mecklenburg Coun Services conducted a COVID-19 Infecti onsite visit on 07/0 07/01/20 - 07/03/20 07/13/20 - 07/15/20	ensure Section and the ty Department of Social d a complaint investigation and on Control Survey with an 1/20, a desk review survey on 0, 07/06/20 - 07/10/20, 0 and a telephone exit on klenburg County Department nitiated the Complaint /30/20.	D 000	Responses to the cited deficient admission or agreement by the f alleged or conclusions set forth i deficiencies. The plan of correct a matter of compliance by law.	facility of the facts	- Arteste
Supervision (c) Staff shall respo an accident or incid	01 Personal Care and ond immediately in the case of lent involving a resident to tervention according to the	D 271	10A NCAC 13F .0901(C) Personal 1 10A NCAC 13F .0901 Personal Care (c) Staff Shall respond immediately i accident or incident involving a resid intervention according to the facility's	and Supervision in the case of an lent to provide care and	
facility failed to resp accordance with the and procedures for (Resident #1) who h venous catheter tha required an immedi			Staff were trained 6/23/2020 and 6/3 on policy and procedure of how to re- emergency situation. Staff will be trained at the time of hire to respond in an emergency situation drills will be conducted by a certified once a quater per shift for no less tha Training on Residents Rights will be available date with the Ombudsman. Residents Rights training conducted completed on 7/31/2020 with all staff Facility will be in compliance by 8/14.	espond to an e on the policy and how n. Emergency response CPR instructor at least an the next year. held on the next by Ombudsman	
06/03/20 revealed: sion of Health Service Regulation	ER/SUPPLIER REPRESENTATIVE'S SIGN	Jucob	U TITLE B/25	(X 2020 If continuation	6) DATE

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	EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		HAL060149	B. WING		07/1	15/2020
NAM	OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY,	STATE, ZIP CODE		
EAS	T TOWNE	4815 NOR		N AMITY ROAD		,
(X4 PRE TA	FIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D	contagious blood bo renal failure (ESRF elevated level of po -There was docume "port in the right upp Review of Resident dated 06/03/20 reve Code", (all intervent started). Review of Resident 05/27/20 revealed F "Full Code". Review of Resident administration recor 06/01/20-06/23/20 r -The heading of the #1's name. -In parenthesis, nex written "Full Code" i Review of the Amer definition of a "Full C -A full code means a interventions neede -This may include cl defibrillation to shoc threatening heart rh -A full code means t any of the above me Review of the facility and Fire Safety Pole	d diabetes mellitus II (DM II), a prine pathogen, end stage) and hyperkalemia (an tassium in the blood), entation Resident #1 had a per chest". #1's Physician's Order Report ealed Resident #1 was a "Full ions needed to get their heart #1's Face Sheet dated Resident #1 was listed as a #1's electronic medication id (eMAR) from evealed: eMAR documented Resident t to the resident's name, was in bold letters. ican Heart Association's Code" revealed: a person will allow all d to get their heart started. hest compressions and k the heart out of a life ythm. he individual is willing to allow pasures.	D 271			
` I	-Remain calm. I -Call for help.	Do not panic				

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL060149 07/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD EAST TOWNE CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 271 Continued From page 2 D 271 -Evaluate the resident. -Call 911 -Determine if the resident was breathing, conscious and check for a pulse. -Administer cardiopulmonary resuscitation (CPR) if appropriate-check for Do Not Resuscitate (DNR status). -Administer first aide as appropriate. -Continue emergency intervention until EMS arrives. Review of the Emergency Medical Services (EMS) report for Resident #1 dated 06/23/20 revealed: -The facility called EMS at 6:11am. -The unit was dispatched to the facility and arrived at 6:16am. -EMS was dispatched to the facility for cardiac/respiratory arrest. -"There were several liters of blood puddled throughout the room." -"The patient's bed was soaked with blood, the patient was covered in blood, his wheelchair was soaked in blood, and there were several puddles in the room of congealed blood," -"It appeared the patient's port in his right upper chest was removed which caused severe bleeding." -"The patient was moved to the floor and CPR was administered." -"While performing CPR, blood spewed out of the chest area where the port was removed." -"Due to the severity of blood loss, EMS consulted the hospital physician to determine if resuscitative efforts should be continued, or if the patient should be pronounced deceased. -The physician felt it was appropriate to pronounce the patient deceased. -"The patient was pronounced deceased at 0629." Division of Health Service Regulation

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	Division of Health Service R	egulation			PONI	IAPPROVED
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		HAL060149	B. WING		07/	15/2020
ľ	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	EAST TOWNE			N AMITY ROAD		
			TTE, NC 28:		,	
	PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
	D 271 Continued From pa	ge 3	D 271			
	 07/01/20 at 9:00am When he arrived o were going into the -Resident #1 was s approximately 3 fee the door to his room The staff were out have on gloves or g There was blood o wheelchair as well a on his bed. The Paramedics ha and goggles. Telephone interview 07/01/20 at 9:10am He responded to a arrest. When he arrived of had just entered the -The Paramedics we protective equipmer gown, gloves and go The report he receis initiated by the facilities. The respondent is the receis initiated by the facilities. The facility staff wa gloves, just face ma gloves, just face ma gloves. Telephone interview (MA) on 07/07/20 at 9:00am to take his field and administer his s - She observed Res 	n the scene, the Paramedics facility. Itting in his wheel chair it away from the bed, facing n. in the hallway and did not owns. In Resident #1, on his as under the wheel chair and ad on gowns, gloves, mask, with the Fire Chief on revealed: facility for a reported cardiac in the scene the Paramedics facility. ere in full level 3 personal of (PPE), which included oggles. ved was that CPR was not ty staff prior to their arrival. essive amount of blood" at the s not wearing gowns or sks. with the first Medication Aide 3:48pm revealed: shift at 5:00am on 06/23/20. lent #1's room around ingerstick blood sugar (FSBS)				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			E SURVEY
		HAL060149	B. WING		07/	15/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
***				AMITY ROAD		
EAST TO	JWNE		TTE, NC 2820			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	D	PROVIDER'S PLAN OF C	ORRECTION	(¥5)
PRÉFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	EACH CORRECTIVE ACT	ON SHOULD BE	(X5) Comple Date
D 271	Continued From page	ge 4	D 271	······································	······································	
	wheelchair and the -The central venous upper chest, was fu -She called to him a -She took his radial pulse. -She yelled to the of the personal care as door for the first res -She did not perform locate any personal -She tried to get a sl it was locked and sh -She did not know w -She thought the PP medication room, bu	catheter, inserted in his right ly dislodged and on the bed. nd he did not answer, pulse and she did not feel a her MA to call 911 and told asistant (PCA) to wait at the ponders, of CPR because she could not protective equipment (PPE), heet from the linen closet but here to find PPE, E might have been in the				
:	07/07/20 at 4:10pm -She was the MA on -7:00am, on 06/23/2	the second shift, 7:00pm 0.				
	and the first MA was and FSBS checks. -The first MA came r	personal care to residents administering medications unning up the hall yelling,				
		of Resident #1's room and wheelchair with his back to				
	-The mattress was s sagging.	the wheelchair and under				
	the wheelchair. -She contacted 911.					}
ł		nistrator next who told the				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		HAL060149	B, WING		07/	15/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY &	STATE, ZIP CODE	<u> </u>	
EAST TO				NAME AN OODE		
		CHARLO	TTE, NC 282	205		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	VIEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUIL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 271	Continued From pa	ige 5	D 271		······	
	-Due to Resident # infection, the MAs of without PPE. -She did not know i medication cart or t -She was looking for themselves so they -While they were st first responders arri Telephone interview at 3:47pm revealed -She worked the firs -When she was firs was instructed the firs -When she was firs was instructed the first the medication corts. -The Administrator p shift and as needed -At the end of each responsible for re-s with supplies, includ Telephone interview at 4:05pm revealed -She worked first sh -When they were tra COVID 19 protocols the staff the protection medication room in -Gloves are kept in	1's diagnosis of a blood borne did not want to perform CPR f there was PPE on the he medication room. or towels or linens to protect could perform CPR. ill looking for protection, the ived. with a third MA on 07/08/20 : st shift as a MA. t hired and initially trained she PPE gowns were located in n and the gloves were on the passed out the masks each shift the MAs were tocking the medication carts ting PPE. with a fourth MA on 07/08/20 iff as a MA. ained earlier this year on the s, the Administrator informed ve gowns were in the a drawer. the conference room and	D 271			
:	and PCAs to place a -Masks were given to	ce on the medication carts at the nurses station. to the staff each shift by the				
	9:30am revealed:	s needed. with a PCA on 07/13/20 at e nurses station (gowns and		••••		

Division of Health Service Regulation

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		
		-				
		HAL060149	B. WING		07/	15/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
EAST TO	WNF	4815 NOR	TH SHARO	N AMITY ROAD		
		All has been a second and a second a s	ITE, NC 28	205		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	jd Prefix Tag	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 271	Continued From pa	ge 6	D 271			*******
	-Masks were kept in were given to the st	n the Administrators office and affice and affice and affice and affice and affice and a shift or as needed.				
	07/09/20 at 3:49pm					
	-At approximately 6 from the second MA was unresponsive a	:19am, she received a call A informing her Resident #1				
	-She instructed the	MA to perform CPR on e first responders arrived.				
	-When she arrived a	at the building at				
		am, she was told the MAs had while waiting for the medics				
	to arrive.	on but the first BAA was that				
		en by the first MA was that the right side of Resident #1				
	and on his bed. The	re was no pulse and he was				
		did not initiate CPR because ything to protect herself.				
:	-The statement give	n by the second MA was that				
	she told the first MA	to start CPR. The first MA				
	MA tried to find towe	els to protect themselves,				
	Before she could fin responders arrived.	d any PPE the first				
		and the Director of Operations				
		ition room, the nurses station room after the incident of				
:	6/23/20.					
	-There were gowns	in the medication room, the				
	nurses station and the -There were gloves	at the nurses station on both				
	carts and in the cont	ference room.				
	-Masks were kept in	good supply in the				}
	Administrators office	e, PR certified staff to perform				ş
:	CPR according to th	e facility's Accident				
		ad Fire Safety Policy.				
5. t. t	Observation of the fa	acility Personal Protective				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		HAL060149	B. WING		07/	15/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		10/2020
E107 **	N. 4. J. L 1					
EAST TO	JWNE		TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(XS) COMPLETE DATE
D 271	Continued From pa	ge 7	D 271			
	Equipment on 07/0 -There were 5 plast disposable gowns li- in the top drawer of -There were 15 plast disposable gowns li- room, in the top dra- cabinet. -There were 10 unc- assorted sizes, locat the top drawer of th -There was 1 unoper disposable gowns a in the bottom drawer carts. Review of the person 4:22pm revealed:	1/20 at 12:45pm revealed: ic packages containing 5 ocated at the Nurse's Station, the desk. stic packages containing 5 ocated in the medication wer and second drawer of the pened boxes of gloves, ited in the medication room, in				
;	with no expiration da Telephone interview on 07/10/20 at 9:20a -She arrived at the f	s CPR certified on 07/29/19 ate listed. with the Regional LHPS RN am revealed: acility on 06/23/20 at				
	-The two MAs were -They had panicked there was blood eve -She asked why the	y did not perform CPR on other said "we did not do CPR				
	Summary report dat -The staff member p Resident #1's cardia	n Care Personnel Registry ed 06/25/20 revealed: present on 06/23/20 during to event refused to initiate ident being a full code and hitiate CPR (by the				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:		E SURVEY
HAL0601		HAL060149	B. WING			15/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS CITY	STATE, ZIP CODE	<u> </u>	10/2020
EAST TO	3\A/NE			N AMITY ROAD		
		CHARLO	TTE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLE DATE
D 271	due to Resident #1 blood borne pathog anything to protect -During the investig adequate PPE loca The staff failed to re facility's policy and cardiopulmonary re #1 who was found in his room and was a policy was to perfor was found unrespon not breathing until E certified staff failed #1, as directed by the was found in his root a pulse. Resident # shortly after the first failure resulted in set a Type A1 Violation.	ed she refused to initiate CPR 's diagnosis of a contagious ien, and she did not have herself. ation, the facility noted ted throughout the facility. espond in accordance with the procedures to provide suscitation (CPR) to Resident unresponsive and bleeding in t "full code". The facility's m CPR whenever a resident nsive, without a pulse and/or EMS arrived. The CPR to perform CPR for Resident neir Administrator, when he om unresponsive and without 1 was pronounced dead t responders arrived. This erious neglect and constitutes	D 271			
:	CORRECTION DAT VIOLATION SHALL 2020.	S. 131D-34 on 07/10/20. TE FOR THE TYPE A1 NOT EXCEED AUGUST 14,				
	(a) An adult care he preparation and adr prescription and nor by staff are in accor	04 Medication Administration ome shall assure that the ninistration of medications, n-prescription, and treatments	D 358	10A NCAC 13F .1004 (a) Medication Admini 10A NCAC 13F .1004 Medication Administra An adult care home shall assure that the pre and administration of medications, prescripti non presciptions, and non treatments by staf accordance with: (1) orders by a licensed pre practioner which are maintained in the reside and (2) rules in this section and the facility's procedures.	ition (a) peration ons and f are in escribing ents records	

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL060149	B. WING		0.77	15/0000
AME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE	077	15/2020
AST TOWNE		TE, NC 28			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) Comple Date
D 358, Continued From pa	ge 9	D 358			
 (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: TYPE A2 VIOLATION 			DRC and Ed will conduct an inservice on correct / Administration documentation for MA including ter completed by 7/17/2020. DRC and RCM will perform an immediate cart aud of all MARS on 7/16/2020 and 7/17/2020 DRC and RCM will perform Med Pass Observatio. All MA will be revaluated by an RN completed on All MA will have training on the 5 and 10 hour Med will be assigned FELS training completed on 7/20 Facility will be in compliance by 8/14/2020	minology was lit and review 15 7/28/2020 Aide Training	
ordered by a license 2 of 5 sampled resid for a contagious blo hypertension, a bloc potassium, fast actin before meals and da with parameters (Re blood pressure med checks with parame prevent blood clots, blood sugars and m phosphorus levels in (Resident #2). The findings are: 1. Review of Reside 04/01/20 revealed d diabetic chronic kidm failure, pulmonary en knee amputation with	inister medications as ad prescribing practitioner for dents, related to medications od borne pathogen, od thinner, elevated levels of ng insulin to lower blood sugar aily blood pressure checks esident #1); and related to ications and blood pressure ters, medications used to medications used to lower edications used to lower high n patients on dialysis				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
	HAL060149	B. WING	77 HANNING BARANCE	07/	15/2020
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
EAST TOWNE			AMITY ROAD		
		TE, NC 282			
PRÉFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X8) COMPLET DATE
D 358 Continued From pa	ige 10	D 358			
Review of Residen revealed: -There was an entr administration at 6: documented as not dialysis" on 05/01/2 dialysis" on 05/04/2 "resident unavailab 05/20/20, 05/22/20 05/29/20 at 6:00am 6:00am. -The Eliquis was do administered 11 our Review of Resident revealed: -There was an entry administration at 6: documented as not 06/15/20 at 6:00am 06/03/20, 06/05/20, 06/17/20 and 06/19/ resident" on 06/09/2 -The Eliquis was do administered 10 our Telephone interview facility's contracted 10:00am revealed: -Resident #2 was on medications that we	t #2's May 2020 eMAR y for Eliquis 5mg scheduled for 00am and 8:00pm and administered, "gone to 0 at 6:00am, "refused going to 0, and 05/11/20 at 6:00am, le" on 05/06/20, 05/13/20, 0, 05/25/20, 05/27/20 and 1, "refused" on 05/15/20 at cumented as not t of 62 opportunities. #2's June 2020 eMAR / for Eliquis 5mg scheduled for 00am and 8:00pm and administered, "dialysis" on 0, "resident unavailable" on 06/06/20, 06/10/20, 06/12/20, /20 at 6:00am, "assisting 20 at 6:00am, cumented as not cof 60 opportunities. with a pharmacist at the pharmacy on 07/09/20 at n a monthly cycle fill for re scheduled. These utomatically sent to the facility	D 358			
filled on 07/06/20 ar 07/20/20.	ies a day, 28 tablets were id 28 tablets were sent out on				
prescribed over a lo	ot receive Eliquis as nger period than a few days, od clotting would increase and				

STATEME	NT OF DEFICIENCIES	egulation (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	ECONSTRUCTION	// 0 0 1	E QUEVEN
	OF CORRECTION	IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		HAL060149	B. WING		07/15/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DORESS, CITY, S	TATE, ZIP CODE		
EAST TO	OWNE		RTH SHARON TTE, NC 282	AMITY ROAD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	()(=)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From pa	age 11	D 358	in and the second se		
	Fistula (AVF, is an	ge to the new Arteriovenous abnormal connection between in, used as a dialysis access				
	Cardiovascular Sur and 07/14/20 at 1:0 -Resident #2 receiv 06/30/20 as a "last port. -Resident #2 had a catheter placed thr right atrium and us	ved a right upper chest AVF on resort" for his dialysis access l left chest wall perma-cath (a ough a vein into or near the ed for dialysis in an emergency a device is ready to use) after				
	b. Review of Reside 04/01/20 revealed a medication used to times a day on Mor (hold for a systolic l	as placed September 2019. ent #2's current FL2 dated an order for Metoprolol (a lower blood pressure) 25mg 2 nday, Wednesday and Fridays, blood pressure less than 110 than 60) at 6:00am and				
	revealed: -There was an entry scheduled for admi 8:00pm documente to dialysis" on 05/0 to dialysis" on 05/0 "resident unavailab 05/20/20, 05/22/20, 05/29/20 at 6:00am 6:00am. -The metoprolol wa	t #2's May 2020 eMAR y for metoprolol 25mg nistration at 6:00am and of as not administered, "gone 1/20 at 6:00am, "refused going 4/20, and 05/11/20 at 6:00am, le" on 05/06/20, 05/13/20, 05/25/20, 05/27/20 and of "refused" on 05/15/20 at s documented as not t of 62 opportunities.				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL060149 07/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD EAST TOWNE CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) D 358 Continued From page 12 D 358 Review of Resident #2's June 2020 eMAR revealed: -There was an entry for metoprolol 25mg scheduled for administration at 6:00am and 8:00pm documented as not administered, "dialvsis" on 06/01/20 at 6:00am, "refused going to dialysis" on 06/22/20 at 6:00am, "resident unavailable" on 06/03/20, 06/05/20, 06/08/20, 06/10/20, 06/12/20, 06/17/20 and 06/19/20 at 6:00am, "refused" on 06/29/20 at 6:00am. The metoprolol was documented as not administered 10 out of 60 opportunities. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/09/20 at 10:00am revealed: -Resident #2 was on a monthly cycle fill for medications that were scheduled. These medications were automatically sent to the facility on a specific date each month. -Metoprolol 25mg twice daily, 28 tablets were filled on 07/06/20 and 14 tablets were sent on 07/20/20. -If Resident #2 did not receive his Metoprolol to lower his blood pressure, as prescribed, it could cause the blood pressure to increase and could cause rebound hypertension (blood pressure rises) and an increase in pulse rate, heart attack or stroke. c. Review of Resident #2's current FL2 dated 04/01/20 revealed an order for clonidine HCL (a medication used to lower blood pressure) 0,2mg three times a day, on Monday, Wednesday and Friday 05/01/20 - 05/06/20, then stop, (hold for a systolic blood pressure less than 110 and a pulse of less than 60) at 6:00am, 2:00pm and 8:00pm. Review of Resident #2's May 2020 eMAR revealed:

Division of Health Service R	egulation			I OI W	MEEROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
	HAL060149	B. WING		07/*	5/2020
NAME OF PROVIDER OR SUPPLIER	STREETAL	DRESS, CITY, S	TATE, ZIP CODE		
FAR FOLK			AMITY ROAD		
EAST TOWNE		TTE, NC 282			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR(DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 358 Continued From pa	nge 13	D 358			(¹ 00)
-There was an entr three times a day 0 Monday, Wednesd scheduled for admi and 8:00pm docum "gone to dialysis" o "refused going to d 6:00am, "resident u 6:00am and "other" -The cionidine HCL administered 4 out d. Review of Reside 04/01/20 revealed a carbonate (a medic phosphorus levels i due to severe kidne	y for clonidine HCL 0.2mg 5/01/20 - 05/06/20, on ay and Fridays, then stop, inistration at 6:00am, 2:00pm lented as not administered, n 05/01/20 at 6:00am, ialysis" on 05/04/20, at inavailable" on 05/06/20 at ' on 05/04/20 at 2:00pm. was documented as not	-			
revealed: -There was an entry 800mg, take 3 table scheduled for admi and 5:00pm docum "gone to dialysis" or "refused going to di 05/11/20 at 7:00am 05/06/20, 05/13/20, 05/27/20 and 05/29 05/15/20 at 7:00am -The sevelamer car not administered 11 Review of Resident revealed: -There was an entry	bonate was documented as out of 93 opportunities. #2's June 2020 eMAR / for sevelamer carbonate				
	ts (2400mg) with meals histration at 7:00am, 12:00pm				

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STATE FORM

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IAME OF PROVIDER OR SUPPLIER EAST TOWNE (X4) ID SUMMARY STATE PREFIX (EACH DEFICIENCY M TAG REGULATORY OR LSC	4816 NOF CHARLO	B. WING			
AST TOWNE (X4) ID SUMMARY STATE PREFIX (EACH DEFICIENCY M	4816 NOF CHARLO	DRESS, CITY, S		07/	15/2020
(X4) ID SUMMARY STATE PREFIX (EACH DEFICIENCY M	4816 NOF CHARLO		TATE, ZIP CODE		
(X4) ID SUMMARY STATE PREFIX (EACH DEFICIENCY M	CHARLO		AMITY ROAD		
PREFIX (EACH DEFICIENCY M		TTE, NC 2820			
TAG REGULATORY OR LSC		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
	CIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE PROPRIATE	COMPLE DATE
D 358 Continued From page		D 358			
 "unavailable resident 06/11/20 at 12:00pm, 8:00am and 06/29/20 06/28/20 at 8:00am, 0 06/30/20 at 8:00am, " 06/03/20, 06/05/20, 0 7:00am, and "residen 06/26/20 at 8:00am, -The sevelamer carbon not administered 12 of Telephone interview w facility's contracted ph 10:00am revealed: -Resident #2 was on a medications that were medications that were medications were auto on a specific date eaco -Sevelamer carbonate (2400mg) with meals, 07/06/20 and 126 tabl 07/20/20. If Resident #2 did not carbonate as prescrib increased levels of ph could increase the risk e. Review of Resident 04/01/20 revealed an blood sugar (FSBS) at at 6:00am and 8:00pm Review of Resident #2 Medication Administra revealed: -There was a entry for 	at unavailable treatment" on onate was documented as out of 90 opportunities. with a pharmacist at the harmacy on 07/09/20 at a monthly cycle fill for e scheduled. These comatically sent to the facility ch month. e 800mg, take 3 tablets , 252 tablets were filled on lets were sent out on t receive the sevelamer bed, it could lead to nosphorus in the body which k of heart attack. t #2's current FL2 dated order to check a finger stick nd record two times a day n. 2's May 2020 electronic				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	HAL060149	B. WING	111111	07/	15/2020
NAME OF PROVIDER OR SUPPLIER	STREETAL	DRESS, CITY, S	TATE, ZIP CODE		
EAST TOWNE		RTH SHARON	AMITY ROAD		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358 Continued From p	age 15	D 358	tat,	·····	
"gone to dialysis" of "refused going to of 05/11/20 at 6:00an 05/06/20, 05/13/20 05/25/20, 05/27/20 "refused" on 05/15 -A FSBS was doou of 62 opportunities Review of Residen revealed: -There was a entry obtained at 6:00an -The FSBS was do "dialysis" on 06/01/ "resident unavailab 06/08/20, 06/10/20 06/19/20, "going to 6:00am and 05/29/ resident" on 06/09/ documentation was 6:00am and 8:00pr A FSBS was docur of 60 opportunities f. Review of Residen dialysis multivitami renal disease, at 6: Review of Residen revealed: -There was an entr scheduled for admi documented as not dialysis" on 05/01/2 dialysis" on 05/01/2 dialysis" on 05/01/2 dialysis" on 05/01/2 dialysis" on 05/01/2	on 05/01/20 at 6:00am, dialysis" on 05/04/20, and n, "resident unavailable" on 0, 05/20/20, 05/22/20, 0 and 05/29/20 at 6:00am, /20 at 6:00am. Imented as not obtained 11 out at #2's June 2020 eMAR r for a FSBS scheduled to be n and 8:00pm ocumented as not obtained, /20, and 06/15/20 at 6:00am, ole" on 06/03/20, 06/05/20, 0, 06/12/20, 06/17/20, dialysis" on 06/22/20 at /20 at 6:00am, "assisting /20 at 6:00am. The s blank 06/23/20 - 06/30/20, at m. nented as not obtained 26 out ent #2's current FL2 dated an order for Dialyvite (a n) 1mg every day for end stage	D 358		·	

STATE FORM

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		HAL060149	B. WING		07/	07/15/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
EAST TO	าเงเน			AMITY ROAD			
		CHARLO	TTE, NC 2820)5			
(X4) ID Prefix Tag	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
D 358	Continued From pa	age 16	D 358				
	6:00am,						
	-The Dialyvite was	documented as not t of 31 opportunities.					
	revealed:	t #2's June 2020 eMAR y for Dialyvite 1mg scheduled					
	for administration a not administered, " 6:00am, "refused g	t 6:00am and documented as dialysis" on 06/15/20 at oing to dialysis" on 06/22/20 at					
	6:00am, "resident u	resident" on 06/09/20 at inavailable" on 06/03/20, . 06/10/20, 06/12/20, 06/17/20 :0am					
	-The Dialyvite was						
		v with a pharmacist at the pharmacy on 07/09/20 at					
	medications that we	n a monthly cycle fill for are scheduled. These utomatically sent to the facility					
	on a specific date e -Dialyvite 1mg ever	ach month. y day, 28 tablets were filled on					
	07/20/20 and 14 tai	plets were sent out on					
	04/01/20 revealed a	ent #2's current FL2 dated an order for Tradjenta (is a lower blood sugars) 5mg n.					
	revealed;	#2's May 2020 eMAR					
	for administration a not administered, "g	/ for Tradjenta 5mg scheduled t 6:00am and documented as jone to dialysis" on 05/01/20 going to dialysis" on					

STATE FORM

Division of Health Service Regulation

ND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	HAL060149	8. WING	**************************************		15/2020
AME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
AST TOWNE			AMITY ROAD		
	CHARLO	TTE, NC 2820)5		
REFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 358 Continued From pa	age 17	D 358			
05/22/20, 05/25/20 6:00am, "refused" -The Tradjenta was	/06/20, 05/13/20, 05/20/20, , 05/27/20 and 05/29/20 at on 05/15/20 at 6:00am, s documented as not it of 31 opportunities.				
revealed: -There was an entr for administration a administered, "dialy "refused going to d 05/11/20 at 6:00am 06/03/20, 06/05/20 06/17/20 and 06/19 resident" on 06/09/ to dialysis" on 06/22 -The Tradjenta was	t #2's June 2020 eMAR y for Tradjenta 5mg scheduled at 6:00am documented as not ysis" on 06/15/20 at 6:00am, lalysis" on 05/04/20, and a, "resident unavailable" on , 06/08/20, 06/10/20, 06/12/20, 0/20 at 6:00am, "assisting 20 at 6:00am, "refused going 2/20 at 6:00am. a documented as not t of 30 opportunities.				
facility's contracted 10:00am revealed: -Resident #2 was o medications that we medications were a on a specific date e -Tradjenta 5mg eve on 07/06/20 and 14 07/20/20. -If Resident #2 did n ordered, it could ca increase.	ery day, 28 tablets were filled tablets were sent out on not receive the Tradjenta as use his blood sugars to				
04/01/20 revealed a medication used to	ent #2's current FL2 dated an order for Vitamin D3 (a help the body absorb calcium 25mcg every day at 6:00am.				
Review of Resident	#2's May 2020 eMAR				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL060149 07/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD EAST TOWNE CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 358 Continued From page 18 D 358 revealed: -There was an entry for Vitamin D3 5000 units scheduled for administration at 6:00am documented as not administered, "gone to dialysis" on 05/01/20 at 6:00am, "refused going to dialysis" on 05/04/20, and 05/11/20 at 6.00am, "resident unavailable" on 05/06/20, 05/13/20, 05/20/20, 05/22/20, 05/25/20, 05/27/20 and 05/29/20 at 6:00am, "refused" on 05/15/20 at 6:00am. The Vitamin D3 was documented as not administered 11 out of 31 opportunities, Review of Resident #2's June 2020 eMAR revealed: -There was an entry for Vitamin D3 5000 units scheduled for administration at 6:00am documented as not administered, "dialysis" on 06/15/20 at 6:00am, "refused going to dialysis" on 06/22/20, at 6:00am, "resident unavailable" on 06/03/20, 06/05/20, 06/08/20, 06/10/20, 06/12/20, 06/17/20 and 06/19/20 at 6:00am, "assisting resident on 06/09/20 at 6:00am. -The Vitamin D3 was documented as not administered 10 out of 30 opportunities, Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/09/20 at 10:00am revealed: -Resident #2 was on a monthly cycle fill for medications that were scheduled. These medications were automatically sent to the facility on a specific date each month. -Vitamin D3 5000 units every day, 28 tablets were filled on 07/06/20 and 14 tablets were sent out on 07/20/20. Telephone interview with the first medication aide (MA) on 07/08/20 at 2:03pm revealed: -Resident #2 was at the front door waiting for his Division of Health Service Regulation

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	F	CONSTRUCTION		SURVEY	
	HAL060149	B. WING		07/	07/15/2020	
NAME OF PROVIDER OR SUPPLIER	R STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
			AMITY ROAD			
		TTE, NC 2820				
	ATEMENT OF DEFICIENCIES	iD	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX (EACH DEFICIENC TAG REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF(X TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE	
D 358 Continued From p	age 19	D 358		······································	· · · · · · · · · · · · · · · · · · ·	
ride to dialvsis bef	ore she got to his hall to					
administer mornin						
	nister any morning medications					
	the days he left for dialysis					
treatment.						
	ective on the eMAR to do					
	on the days Resident #2 went					
out to dialysis.	if Resident #2 received his					
	ins when he returned from					
dialysis.						
Telephone intervia	w with a second MA on					
07/08/20 at 2:33pn						
	ed to take his morning					
medications on dia						
	ask him if he wanted to take					
	nile he was waiting for his ride					
to the treatment ce	-					
	o take any medication before					
his dialysis treatme					Į	
	nister morning medications to mornings he went to dialysis.					
	ing when Resident #2 returned					
	he did not know if he was					
	orning medications when he					
returned from dialy						
Telephone interview	w with the nurse practitioner					
(NP) on 07/08/20 a	at 4:44pm revealed:					
	nformed the NP that he did not	1 I				
	edications before dialysis but				1	
them at all.	w Resident #2 did not receive					
	ceived them when he returned					
	facility should have had the					
times of administra						
	to be notified when a resident					
was not receiving t	heir medications,					
الاحت المتحد والمراجع والمراجع والمراجع المراجع المراجع المراجع والمراجع والم	usted the medication	1 1			1	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	E CONSTRUCTION		E SURVEY PLETED
·····		HAL060149	B, WING		07/	15/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
EAST TO	WNE		RTH SHARON TTE, NC 2820	AMITY ROAD		
(X4) ID PREFIX TAG	(EACH DEFIGIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X8) COMPLET DATE
D 358	Continued From pa	nge 20	D 358			
	administration sche Resident #2's dialy	edule to accommodate sis treatment,				
	Refer to telephone Administrator on 07					
!	Refer to telephone aide (MA) on 07/08	interview with a medication /20 at 2:03pm.				
	Refer to telephone 07/08/20 at 2:33pm	Interview with a second MA on				
	07/08/20 at 3:47pm	interview with a third MA on ent #1's current FL2 dated				
	-Diagnoses include contagious blood bo renal failure (ESRF)	d diabetes mellitus II (DM II), a orne pathogen, end stage) and hyperkalemia. entation Resident #1 had a oer chest".				
	Order Report dated an order for abacav	ent #1's signed Physician 06/03/20 revealed there was ir 300mg, two tablets (600 d to treat the progression of a orne pathogen.				
	administration recor through 06/22/20 re -There was a comp	uter generated entry for				
	scheduled to be adr - Abacavir 600mg w administered on 06/ 06/11/20, 06/16/20,	tablets (600mg) daily ministered at 8:30am. /as not documented as /02/20, 06/06/20, 06/10/20, 06/18/20, and 06/20/20.				
		ented on the eMAR by the IAs) was "out of the facility"				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		A. DUILDING;	Ma		anders beil den
	HAL060149	B, WING	1997	07/1	5/2020
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EAST TOWNE		RTH SHARON TTE, NC 282	NAMITY ROAD		
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
D 358 Continued From pa	ige 21	D 358		**************************************	
-Abacavir was docu out of 22 opportuni	umented as not administered 7 tles.				
 facility's contracted 2:41pm revealed: The pharmacy star medications upon a Resident #1 was or medications that we medications were simonth. -As needed (PRN) filled as needed. -Abacavir 300mg, trablets were filled or 06/17/20. -If Resident #1 did trablets were filled or 06/17/20. -If Resident #1 did trablets were filled or 06/17/20. -If Resident #1 did trablets were filled or 06/17/20. -If Resident #1 did trablets were filled or 06/17/20. -If Resident #1 did trablets were filled or 06/17/20. -If Resident #1 did trablets were filled or 06/17/20. -If Resident #1 did trablets were filled or 06/17/20. -If Resident #1 did trablets were filled or 06/17/20. -If Resident #1 did trablets were filled or 06/17/20. -If Resident #1 did trablets were filled or 06/17/20. -If Resident #1 did trablets were filled or 06/17/20. -If Resident #1 did trablets were filled or 06/17/20. -If Resident #1 add trablets were filled or 06/17/20. -If Resident #1 santic contagious blood be administered consistent contagious blood be administered consistent. -He would expect the changed to the after Resident #1 returned -He would expect to not receiving their santic receiving their santic reason. b. Review of Reside Order Report dated 	with Resident #1's nurse 07/08/20 at 4:44pm revealed: viral medication for a prine pathogen had to be stently to be effective. The medication times to be rnoon, and administered when ad from dialysis. To be notified if a resident was cheduled medications for any ent #1's signed Physician 06/03/20 revealed there was grel 75mg, one tablet daily,				

STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING;	CONSTRUCTION		e survey Pleted
Marra No		HAL060149	B. WING		07/	15/2020
NAME OF PROVIDER OR	SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
EAST TOWNE				AMITY ROAD		
		CHARLO	TTE, NC 2820)5		
PRÉFIX (EACH I	DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 358 Continued	From pa	ge 22	D 358			
06/01/20 ti -There was clopidogre administer -Clopidogr administer 06/11/20, (-The reason MAS was " -Clopidogr administer Telephone facility's co 2:41pm rev -Clopidogr 05/27/20 a -If Residen few days, ti he did not over a long potential for Telephone 07/08/20 a -Since Res central ven if he did not -He would changed to Resident # -He would not receivir reason.	nrough 06 s a compi- l 75mg da ed at 8:30 el was no ed on 06/ 06/16/20, on docum- out of the el was do ed 7 out of interview realed: el 75mg c nd 14 tab t #1 did n here wou receive the er period cl interview t 4:44pm ident #1 h ous cathe t receive expect the after; 1 returned expect to ig their sc	t documented as 02/20, 06/06/20, 06/10/20, 06/18/20, and 06/20/20. ented on the eMAR by the facility (OOF). cumented as not of 22 opportunities. with the pharmacist at the oharmacy on 07/09/20 at laily, 28 tablets were filled on lets were filled on 06/17/20. ot receive clopidogrel over a ld be no acute symptoms. If e medication as prescribed than a few days, the otting would increase. with Resident #1's NP on revealed: had an upper right chest ater, he was at risk of clotting his blood thinner regularty. e medication times to be noon, and administered when d from dialysis. be notified if a resident was sheduled medications for any		·		
Order Repo	ort dated (nt #1's signed Physician 06/03/20 revealed there was 50mg, one tablet daily, used				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
	1	A BUILDING	,	00101	:
	HAL060149	B. WING		07/*	15/2020
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, 3	STATE, ZIP CODE		
EAST TOWNE		RTH SHAROI TTE, NC 28:	N AMITY ROAD		
(X4) ID SUMMARY ST/	ATEMENT OF DEFICIENCIES	1		ODDEATION	1
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358 Continued From pa	age 23	D 358			
to treat the progres pathogen.	sion of a blood borne				
06/01/20 through 0 -There was a comp Tivicay 50mg daily, at 8:30am. -Tivicay was not do 06/02/20, 06/06/20 06/18/20, and 06/20 -The reason docum MAs was "OOF" (o -Tivicay was docum out of 22 opportunit Telephone interview facility's contracted 2:41pm revealed: -Tivicay 50mg daily 05/27/20 and 14 tal -If Resident #1 did in days there would be not receive the med longer period of tim develop an increase medication. Telephone interview 07/08/20 at 4:44pm -Resident #1's antii contagious blood bo administered consis -He would expect the changed to the afte	outer generated entry for scheduled to be administered cumented as administered on . 06/10/20, 06/11/20, 06/16/20, 0/20. hented on the eMAR by the ut of the facility). hented as not administered 7 dies. with the pharmacist at the pharmacy on 07/09/20 at . 28 tablets were sent on olets were sent on 06/17/20. hot receive Tivicay for a few a no acute symptoms. If he did lication as prescribed over a e, than a few days, he would ed resistance to the with Resident #1's NP on revealed: viral medications for a orne pathogen had to be stently to be effective. he medication times to be moon, and administered when				
Resident #1 returne -He would expect to	d from dialysis. be notified if a resident was cheduled medications for any				
Division of Health Sarvice Regulation			·····		

Division of Health Service Regulation

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	HAL060149	B. WING		07/	15/2020
IAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
AST TOWNE		RTH SHARON TTE, NC 2820	AMITY ROAD 05		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Order Report dated an order for metop tablet (12,5mg) even hypertension. Review of Residen 06/01/20 through 0 -There was a comp metoprolol tartrate administered twice -Metoprolol tartrate administered on 06 06/11/20, 06/16/20 -The reason docun MAs was "OOF" (o -Metoprolol was do 7 out of 22 opportu Telephone interview facility's contracted 2:41pm revealed: -Metoprolol tartrate were filled on 05/27 on 06/17/20. -Resident #1 could hypertension (a rise increase in pulse ra stopped or lowered Telephone interview 07/08/20 at 4:44pm -He was concerned administered metop -Resident #1 could or above.	ent #1's signed Physician d 06/03/20 revealed there was rolol tartrate 25mg, one half ery 12 hours, used to treat t #1's June 2020 eMAR from 6/22/20 revealed: buter generated entry for 12.5mg scheduled to be daily at 8:30am and 8:30pm. was not documented as 6/02/20, 06/06/20, 06/10/20, 06/18/20, and 06/20/20, bented on the eMAR by the ut of the facility). cumented as not administered nities. v with the pharmacist at the pharmacy on 07/09/20 at 12.5mg twice daily, 28 tablets 1/20 and 14 tablets were sent experience rebound a in blood pressure) and an the if the medication was v with Resident #1's NP on revealed: Resident #1 was not prolol on dialysis days. spike a blood pressure of 180 equently over a 2 month	D 358			

Division	of Health	Service	Regulation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
	HAL060149	B. WING		07/1	5/2020
NAME OF PROVIDER OR SUPPLIEF			STATE, ZIP CODE		
EAST TOWNE		TH SHARO	N AMITY ROAD 205		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
an order for Renag times a day with m of potassium in the Review of Resider 06/01/20 through (-There was a com Renagel 800mg, o meals, scheduled 12:00pm and 5:00 - Renagel was not on 06/02/20, 06/06 06/16/20, 06/18/20 - The reason docur MAs was "OOF" (o -Renagel was docu out of 22 opportuni Telephone interview facility's contracted 2:41pm revealed R	d 06/03/20 revealed there was gel 800mg, one tablet three heals, used to treat an increase a blood (hyperkalemia). at #1's June 2020 eMAR from 06/22/20 revealed: buter generated entry for ne tablet three times a day with to be administered at 7:00am, om. documented as administered /20, 06/10/20, 06/11/20, , and 06/20/20. nented on the eMAR by the but of facility). imented as not administered 7 ties. w with the pharmacist at the pharmacy on 07/09/20 at lenegal 800mg, one tablet	D 358			
three times daily, 8 05/27/20 and 42 ta f. Review of Reside Order Report dated an order for blood pres- administer clonidin 6 hours. Review of Residen 06/01/20 through 0 -There was a comp pressure checks or 7:00am and 3:00pr pressure was great clonidine 0.6mg events	4 tablets were sent on blets were sent on 06/17/20. ent #1's signed Physician 1 06/03/20 revealed there was pressure checks daily. If sure was greater than 160 e 0.6mg as needed (prn) every t #1's June 2020 eMAR from 6/22/20 revealed: outer generated entry for blood nee a day scheduled between n. If the systolic blood er than 160, administer				

Division of Health Service F	Regulation			FORM	APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		e survey Pleted
	HAL060149	B, WING		07/	15 (0000
NAME OF PROVIDER OR SUPPLIER	STREETA	DRESS. CITY S	TATE, ZIP CODE	077	15/2020
EAST TOWNE	4815 NO		AMITY ROAD		
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X6) COMPLET DATE
D 358 Continued From pa	age 26	D 358		<u></u>	
06/11/20, 06/16/20 -The reason docun MAs was "OOF" (o -The blood pressur not administered 7 Telephone interview facility's contracted 2:41pm revealed cl pressure greater th on 05/27/20. Telephone interview 07/08/20 at 4:44pm -He was concerned his blood pressure f -Resident #1 could or above.	re checks were documented as out of 22 opportunities. w with the pharmacist at the pharmacy on 07/09/20 at onidine 0.6mg prn for blood an 160, thirty tablets were sent v with Resident #1's NP on revealed: Resident #1 was not having taken on dialysis days. spike a blood pressure of 180 d blood pressure could cause				
Order Report dated an order for Humulit inject 5 units before elevated blood suga fingerstick blood sug and notify the physic 400. Review of Resident 06/01/20 through 06 -There was a compu- Humulin R U-100 inj schedujed to be adm	uter generated entry for ect 5 units before each meal ninistered at 6:30am.				
70 and notify the phy than 400.	n. Hold if FSBS was less than /sician if FSBS was greater s not administered at				

Division of Health Service Regulation					
	Division	of	Health	Service	Regulation

E Contraction of the second seco	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	E CONSTRUCTION		SURVEY
	I OF BORREOTION	INCOLUCION NOTINEEK.	A. BUILDING		COMPLETED	
		HAL960149	B. WING		07/*	15/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·	
EAST T	OWNE			N AMITY ROAD		
			TTE, NC 282	205		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 27	D 358			
	11:30am on 06/02/2 06/10/20, 06/11/20, -The reason docum MAs was "OOF" (ou -Humulin R 5 units administered 6 out of 11:30am. Telephone interview facility's contracted 2:41pm revealed: -Resident #1 was or medications that we -Insulin and PRN me pharmacy staff as ne -Humulin R 5 units t sent on 05/27/20. -At 5 units daily,1 via days.	20, 06/04/20, 06/06/20, and 06/12/20, ented on the eMAR by the at of the facility). was documented as not of 13 opportunities at with the pharmacist at the pharmacy on 07/09/20 at a monthly automatic fill for re scheduled. edications were filled by the eeded. hree times daily,1 vial was al of Humulin would last for 30				
	07/08/20 at 4:44pm -He was not aware F his morning medicat dialysis treatment. -Resident #1's insuli	Resident #1 was not receiving ions on the days he had n had to be administered				
	blood sugar. -He expected to be r receiving his schedu reason. -He discontínued Re	neals to maintain a stable notified if a resident was not led medication for any sident #1's Humulin before ue to low FSBS readings.				
ivision of H	on 07/08/20 at 2:03p -She checked Resid administered 5 units mornings she worker	ent #1's FSBS and of Humulin insulin on the				

Division of Health Service STATE FORM

Division of Health Service F	Regulation			FURI	APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
	HAL060149	B. WING		07/	15/2020
NAME OF PROVIDER OR SUPPLIER	R STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
			AMITY ROAD		
EAST TOWNE		TTE, NC 282			
PREFIX (EACH DEFICIEN)	IATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
D 358 Continued From p	age 28	D 358			
 -He refused his in: was too low. -There was no dire anything different out to dialysis. -She did not know morning medication dialysis. Telephone intervie 07/08/20 at 2:33pr -She checked Res administered 5 uni mornings she work -Resident #1 was of -If Resident #1 tho the morning, he work insulin. -She did not work work 	ident #1's FSBS and ts of Humulin insulin on the ked. compliant with his medications. ught his FSBS was too low in puld refuse his scheduled when Resident #1 returned lid not know what medications				
at 3:47pm revealed -She administered her shift. -On the days he we Thursday and Satu FSBS when he retu -When Resident #1 "picked up on his s	medications to Resident #1 on ent to dialysis, Tuesday, irday, she would check his urned. 1 returned from dialysis, she icheduled medications".				
administered media were scheduled. -She did not notify missed several me because she had d facility at his treatm	irned at 2:00pm, she cations after 2:00pm as they the NP Resident #1 had dications while at dialysis, ocumented he was out of the nent. ident #1 was not at dialysis				

1

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
·		TH DOLDING.				
	HAL060149	B. WING		07/1	15/2020	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EAST TOWNE		TH SHARON TE, NC 282				
	TEMENT OF DEFICIENCIES	1				
PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 358 Continued From pa	ige 29	D 358				
and he missed his fax to the NP.	medications, she would send a					
at 10:10am reveale -She checked Resi administered his in: -Resident #1 left for 9:00am or 10:00am -The morning medi missed were due to Tuesday, Thursday -She documented F the facility) as the re- medications. -"Everyone knows h NP and manageme -If a resident was no medications were d administer them. -There was no facili medications. -She would fill out a and fax it to the NP parameters were ou falls or other health -She did not send a medications on day because everyone h dialysis. -The physician, the Administrator and th at dialysis on Tuesd	dent #1's blood sugar and sulin in the morning. r dialysis treatment around h. cations that Resident #1 b his dialysis treatments on and Saturday. Resident #1 was "OOF" (out of eason he missed his he was at dialysis." (The staff, nt) of in the building when his ue she was not required to ty policy for missed Health Care Concern form if blood pressure or insulin it of range, a resident had		·			
out of the building."	nterview with the first MA on					
Refer to telephone i	nterview with a second MA on	······	·····			

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		E SURVEY PLETED
****		HAL060149	B, WING		07/	15/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S		1 017	1012020
				AMITY ROAD		
EAST TO	JWNE		TTE, NC 282			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	i id	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET
D 358	Continued From pa	ge 30	D 358		······································	
	07/08/20 at 2:33pm					
	Refer to telephone i 07/08/20 at 3:47pm	interview with a third MA on				
	Refer to telephone i Administrator on 07,					
	-She was never inst medications to resid facility when they rei -It was the responsil to the primary care p medications, refused symptom or an accid -She did not fax the missed their medica dialysis treatment. -She documented th facility and that was -Everyone knew whe dialysis treatment. (T management). -If a medication was when they returned th know how to docume	bility of the MA to send a fax chysician if a resident missed d medications, had a new dent/incident. physician when a resident tions the morning of their ne resident was out of the sufficient. en residents were at their The staff, the physician and administered to a resident from dialysis, she would not		·		
	07/08/20 at 2:33pm -She was the MA fro -She administered 6 -Some residents who chose not to take the treatment. "It was the	revealed: m 7:00pm-7:00am. :00am-7:00am medications. o had dialysis treatments eir medications before their eir choice."				
		ow that would be dent was administered their was documented as "out of				

Division of Health Service F	Regulation			FURM	IAPPROVED
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION		F OLDUCK
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:				e survey Pleted
· ·		DOICDING.			
	HAL060149	B. WING			
				07/	15/2020
NAME OF PROVIDER OR SUPPLIEF	011122174		STATE, ZIP CODE		
EAST TOWNE			AMITY ROAD		
		TTE, NC 282	05		
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES	ID · I	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX (EACH DEFICIENC TAG REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO	OULD BE	COMPLETE
		TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
			DE HOICHUT/		
D 358 Continued From p	age 31	D 358			
the facility",					
	a fax to the physician if a				1
resident missed a	medication, had a new health				
	Il or other medical concern.	[
	s medication, like insulin, she				
would send a fax a	after one missed dose,				
-Other medications	s she may wait for 2 missed				
doses before notif	/ing the physician.	1			
-She would not sei	nd a fax to the physician if the				
resident missed m	edications on a day they went				
to dialysis.					
-"Everyone (the sta	aff, the physician and	}			
management) kno	w on dialysis days the resident				
	he facility) for medications to				;
be administered,					
	ent OOF (out of facility) on the				
eMAR on those da	ys.				
Telephone interview	w with a third MA on 07/08/20				
at 3:47pm revealed	₩ ₩11 a third 10//00/20 1-				
	,, om 7:00am-7:00pm,				
	before and an hour after the				
	the administration of				
medications.					
	ut of the building during that				
time frame, she do	cumented "OOF" as the				
reason the medical	tion was not administered.				
	the physician if a resident has				
	dications while at dialysis,				
because she had d	ocumented he was out of the				
facility at his treatm	ent.				
-The physician che	cks the eMARS regularly and				
was able to see the	resident had missed				
medications on dial					
-She had not been	Instructed on what to do with				
	esidents were at dialysis.				1
	eduled and re-occurring event				
and that was the re	ason the staff did not notify the				1
	dications were missed on				
dialysis days.					
ivision of Health Service Regulation					I

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<u> Division of Health Service R</u>	Regulation			FORM	1APPRO\
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY
	HAL060149	B. WING			
AME OF PROVIDER OR SUPPLIER				07/	15/2020
EAST TOWNE		TTE, NC 282	I AMITY ROAD 05		
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CO	RECTION	(1/1)
PREFIX (EACH DEFICIENC TAG REGULATORY OR I	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BF	(X5) COMPLE DATE
D 358 Continued From pa	age 32	D 358			··
Telephone interview	u u della the of descent and a second				
07/09/20 at 3:49pn	w with the Administrator on				
	S Registered nurse (RN) and				
she reviewed the e					
-The process was t	to look for medications not				
signed for by the M	As, medications not				
administered and t	he reason, blood pressure and				
	insulin administration and				
exceptions,	dialysis residents were not				
receiving their more	dialysis residents were not ning medications on the days				
they received dialys	sis treatment				
	this was overlooked during the				
eMARS review.	-				
-She did not know v	why the medications were not				
	they returned from treatment.				
	as that when medications were				
attention.	would be brought to her				
-The MAs should n	otify the prescribing				
physician's with a fa	ax if medications are missed.				
	MAs to inform her when the				
medications on the	eMAR needed to be adjusted.				ĺ
-She could not expl	ain why the MAs thought not				
administering medi	cations 3 times a week when a				
résident was at dial	ysis was a correct procedure.				
The facility failed to	administer medications as				
ordered for Resider	It #1 related to medications for				
a contagious blood	borne pathogen which needed				
to be administered	as scheduled for effectively				
slowing down the p	rogression of the virus, a				
nypertensive medic	ation with blood pressure				
thinner for the prove	ent a possible stroke, a blood ention of clotting with a central				
venous catheter an	id a fast acting insulin before				
' meals to prevent hy	perglycemia (an increase in				1
blood sugar); Resid	ent #2 related to a blood				
thinner resulting in t	he risk for increased blood]

Division of Health Service Regulation

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURV COMPLETE	
	······································	HAL060149	8, WING	аннын налагын алагын алагын алагы алагын алагы алагын алагын алагын алагын алагын алагын алагын алагын алагын а Алагын алагын	07/15/20)20
NAME OF	Provider or Supplier Dwne	4815 NOF		STATE, ZIP CODE N AMITY ROAD 205		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE CO	(X5) MPLET DATE
D 358	hypertensive medic increased blood pre and a heart attack of used to lower phose dialysis resulting in failure resulted in se constitutes a Type A A plan of protection facility in accordance 07/14/20 for this vice THE CORRECTION	arteriovenous fistula, a action resulting in the risk of assure, rebound hypertension, or stroke, and a medication ohorous levels in patients on the risk of a heart attack. This arious neglect which A2 Violation. was requested from the as with G.S. 131D-34 on	D 358			
D 367	 (j) The resident's m record (MAR) shall following: (1) resident's name (2) name of the med (2) name of the med (3) strength and dos administered; (4) instructions for a or treatment; (5) reason or justified medications or treat documenting the ref (6) date and time of (7) documentation of medications or treat omission, including (8) name or initials of 	04 Medication Administration nedication administration be accurate and include the dication or treatment order; sage or quantity of medication administering the medication eation for the administration of tments as needed (PRN) and sulting effect on the resident; administration; of any omission of tments and the reason for the	D 367	 10 A NCAC 13F .1004(J) Medication Administration The residents administration record (MAR) shat accurate and include the following: (1) residents name (2) name of medication or treatment order (3) strength and dosage or quantity of medication administered. (4) instructions for administering medication or (5) reason or justification for the administration medications or treatments as needed(PRN) and documenting the resulting effect on the residen (6) date and time of administration (7) documentation of any omission of medication, inc refusals: and, (8) name and initials of the person administerin medication or treatment. If initials are used, a si equivalent to those is to be documented and m with the medication administration rescord (MAR) Facility will ensure the residents medication admini rescord(MAR) is accurate. Facility ED,RCC,DRC and/or designee will review eMARs for accuracy no less than monthly for one 	n(j) II be on treatment of t ns or luding g the gnature aintained R). nistration	

STATE FORM

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	SURVEY
		HAL060149	B. WING		07/1	5/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
EAST TO	DWNE		RTH SHARC TTE, NC 28	N AMITY ROAD 205		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
D 367	Continued From pa	ge 34	D 367			-
	signature equivalen	t to those initials is to be		Continued from page 34		
	administration record	aintained with the medication		Then randomly there after.		
				Facility MA have been trained on medication add documentation including terminology on 7/17/20	ministration 20	1
				Facility will be in compliance by 8/14/2020		
	This Rule is not me	t as evidenced by:				
•	facility failed to ensu electronic Medicatio	views and interviews, the ire the accuracy of the n Administration Records esidents (Resident #5) ation of oxygen.				
	The findings are:					
	dated 06/22/20 reve -Diagnoses included					
	-An order for oxygen	as needed.				
	order dated 06/22/20	#5's subsequent physician's) revealed a clarification for asal cannula as needed for (SOB).				
	2020 electronic Medi (eMAR) revealed:	#5's June 2020 and July ication Administration Record				
·	via nasal cannula as breath.	ed entry for oxygen 2 litters needed for shortness of				
	 I here was no docur alth Service Regulation 	nentation Resident #5's				

Division of Health Service Regulation

	(T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		E SURVEY PLETED
			A. BUILDING	·	000	E-E- E-E-
		HAL060149	B. WING		07/	15/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
EAST TO	WNE		RTH SHARO TTE, NC 28:			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1			L
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From pa	ge 35	D 367			
	oxygen was adminis through 07/01/20	stered as needed 06/23/20				
	health nurse on 07/ -She had seen Resi follow-up due to retu an order for oxygen.	ygen in his room and was				
	07/09/2020 at 1:35p -He was recently in pneumonia. -The hospital ordere SOB. -The oxygen was de weeks ago in June 2 -He applied the oxyg he ambulated in the outside the building	the hospital for COPD and ed oxygen because he was elivered to his room about 2 2020. gen several times daily after facility or after he went				
	Care Provider (PCP) revealed: -Resident #5 was ac 2020 and June 2020 pneumonia and a pu- Resident #5 was or June 2020 after the -The facility staff wer documenting all med administered on the -He wanted to know #5 received when he a visit.	dered oxygen for his SOB in last hospital admission. re responsible for dications Resident #5 was eMAR. all the medications Resident e reviewed the eMAR prior to				
		staff to document Resident				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4	E CONSTRUCTION		E SURVEY PLETED	
		HAL060149	B. WING		07/	07/15/2020	
NAME OF	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE			
EAST TO	NUME			AMITY ROAD			
	244140		TTE, NC 282				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
D 367	Continued From pe	ige 36	D 367				
	#5's oxygen becaus history and his COI	se Resident #5's respiratory PD.					
	on 07/10/20 at 9:30 -She was aware Re oxygen 2L NC as n -She was aware Re	esident #5 had an order for eeded. esident #5 had oxygen in his					
	oxygen as needed	ed for SOB, ented the administration of the on Resident #5's eMAR. v with a second MA on					
	07/10/20 at 10:10ar -She knew Residen hospital with an ord -She knew Residen	m revealed: it #5 came back from the					
	-She never docume	ented the administration of the on Resident #5's eMAR.					
	facility's contracted 2:28pm revealed:	/ with a pharmacist from the pharmacy on 07/09/20 at					
	entry for oxygen on -The pharmacy did	not enter the order on the					
oxy TT-	oxygen as a medica -The MAs should be	nd they do not consider the ation order. e documenting all as needed atments on the eMAR.					
	Professional Support revealed there was had a task for oxyge	#5's Licensed Health rt (LHPS) dated 06/30/20 documentation Resident #5 an use as needed and the competency validated.					
	·	with the Administrator on					

STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: HAL060149 B. WING 07/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD EAST TOWNE CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION In (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING (NFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 367 Continued From page 37 D 367 07/10/20 at 10:30am revealed: -She knew Resident #5 wore his oxygen in his room for SOB but was not showing signs of SOB since he returned from the hospital in June 2020. -She was unaware the MAs were not documenting Resident #5's oxygen on the eMAR. -She expected the MAs to document all as needed medications on the eMAR's. D912 G.S. 131D-21(2) Declaration of Residents' Rights D912 D912 G.S. 131D-21 (2) Declaration of Residents Rights G.S. 131D-21 Declaration of Residents Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following 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 2. To receive care and services which are state laws and rules and regulations. adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. Staff were trained on policy and procedure of how to respond to an emergency situation. on 6/23/2020 and 6/30/2020 This Rule is not met as evidenced by: ED, RN reviewed residents rights with all staff completed Based on interviews and record reviews, the on 7/17/2020 In-service with all staff on residents right conducted by facility failed to assure residents received care Ombudsman completed via zoom on 7/31/2020 and services which were adequate, appropriate. DRC,ED conducted an in-service on correct Medication Administration, documentation for MA including terminology and in compliance with relevant federal and state completed on 7/17/2020 laws and rules and regulations as related to personal care and medication administration. Facility will be in compliance by 8/14/2020 The findings are: 1. Based on record reviews and interviews, the and in facility failed to respond immediately and in accordance with the facility's established policy and procedures for 1 of 5 sampled residents (Resident #1) who had bleeding from a central venous catheter that became dislodged which required an immediate emergency response. [Refer to Tag 0271, 10A NCAC 13F .0901 (c) Personal Care (Type A1 Violation)]. Division of Health Service Regulation

Division of Health Service Regulation

Division of Health Service Regulation			FORMAPPROVE		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURV COMPLETE	
	HAL060149	B, WING		07/15/20)20
NAME OF PROVIDER OR SUPPLIE	R STREET AL	DRESS, CITY,	STATE, ZIP CODE	01110120	
EAST TOWNE			ON AMITY ROAD		
		TTE, NC 28			
PREFIX (EACH DEFICIEN)	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BELCO	(X5) MPLETE DATE
D912 Continued From p	age 38	D912			···
facility failed to ad ordered by a licen 2 of 5 sampled res for a contagious b hypertension, a ble potassium, fast ac before meals and with parameters (F blood pressure me checks with param prevent blood clots blood sugars and phosphorus levels (Resident #2). [Re	d reviews and interviews, the minister medications as sed prescribing practitioner for sidents, related to medications lood borne pathogen, bod thinner, elevated levels of ting insulin to lower blood sugar daily blood pressure checks Resident #1); and related to adications and blood pressure neters, medications used to a, medications used to lower medications used to lower high in patients on dialysis fer to Tag 0358 10A NCAC 13F in Administration (Type A2				
G.S. 131D-21 Dec Every resident sha	eclaration of Residents' Rights laration of Residents' Rights Il have the following rights: intal and physical abuse, tation.	D914	D914 G.S.131D-21(4)Delcaration of Resider G.S.131D-21 Declaration of Residents Right Every resident shall have the following rights 4. To be free of mental, and physical abuse, and exploitation.	s. ::	
TYPE A1 VIOLATI Based on record re facility failed to ens neglect for 2 of 5 s one resident (#1) w a "Full Code" statu pulmonary resuscit arrest due to blood catheter that was d who had received a	et as evidenced by: DN eviews and interviews, the ure residents were free of ampled residents related to who had a physician's order for s and did not receive cardio ation (CPR) when in cardiac loss from a central venous islodged; and a resident (#2) a new surgical Arteriovenous s port) on 06/30/20 with	ç	ED,RN Immediately reviewed residents rights staff on 7/17/2020. In-service with all staff on residents rights cor Ombudsman via zoom completed on 7/31/20 ED, DRC reviewed with all staff CPR and how respond in an emergency situation on 6/23/2020 and 6/30/2020 In-service with all staff on Dialysis patients, th difference of an established and un establishe port, and what to look for. conducted by Collins Fomunung NP.on 7/22/2020 Facility will be in compliance by 8/14/2020	nducted by 20 w to	

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL060149 B, WING 07/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD EAST TOWNE CHARLOTTE, NC 28205 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION 1D (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D914 Continued From page 39 D914 discharge instructions and his CPAP machine and tubing due to unclean conditions and not providing a full face mask (Resident #2). 1. Review of Resident #1's current FL2 dated 06/03/20 revealed: - Diagnoses included diabetes mellitus II (DM II), a contagious blood borne pathogen, end stage renal disease (ESRD) and hyperkalemia. -There was documentation Resident #1 had a "port in the right upper chest". Review of Resident #1's Resident Register revealed an admission date of 05/27/20. Review of the American Heart Association's definition of a Full Code revealed: -A full code means a person will allow all interventions needed to get their heart started, -This may include chest compressions and defibrillation to shock the heart out of a life-threatening heart rhythm. a. Review of Resident #1's Physician's Order Report dated 06/03/20 revealed Resident #1 was a "Full Code". Review of Resident #1's Resident Register dated 05/27/20 revealed Resident #1 was listed as a Full Code. Review of Resident #1's electronic medication administration record (eMAR) from 06/01/20 through 06/23/20 revealed documentation of "Full Code" in bold letters next to Resident #1's name. Review of the facility's Accident /Falls/Emergency and Fire Safety Policy revealed: -When an accident or emergency occurs, staff should: Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
	HAL.060149	B. WING		07/15/2020	
NAME OF PROVIDER OR SUPPLIER	STREETA	DRESS, CITY, S	TATE, ZIP CODE		

EAST TOWNE		TTE, NC 282			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
D914 Continued From pa	ge 40	D914	······		
conscious and cheo -Administer card (CPR) if appropriate Resuscitate (DNR s -Administer first -Continue emer arrives. Review of the Emer (EMS) report for Re revealed: -The facility called E -The facility called E -The facility called E -The unit was dispat arrived at 6:16am, -EMS was dispatched individual experienci -There were several throughout the room -"The patient's bed v patient was covered soaked in blood, and in the room of conge -"It appeared the pal chest was removed bleeding." -"The patient was me was administered." -"While performing O chest area where the -EMS tried to control difficult. -"Due to the severity consulted the hospita resuscitative efforts of patient should be pro-	e resident is breathing, k for a pulse. diopulmonary resuscitation scheck for Do Not status). aide as appropriate. gency intervention until EMS gency Medical Services sident #1 dated 06/23/20 EMS at 6:11am. tched to the facility and ed to the facility for an ing cardiac/respiratory arrest. I liters of blood puddled ." was soaked with blood, the in blood, his wheelchair was there were several puddles blood." tient's port in his right upper which caused severe oved to the floor and CPR CPR, blood spewed out of the port was removed." the blood flow but it was of blood loss, EMS al physician to determine if should be continued, or if the				

STATE FORM

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY
		HAL060149	B. WING			4 5 10 0 0 0
NAME OF	PROVIDER OR SUPPLIER	STREET AD	ORESS CITY S	TATE, ZIP CODE	1 07	15/2020
EAST TO						
		CHARLOI	TE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X6) COMPLE DATE
D914	Continued From pa	ge 41	D914			
	CPR, the physician pronounce the patie -"The patient was p 0629." Telephone interview 07/01/20 at 9:00am -He responded to the who was "stiff, cold	ronounced deceased at / with a first responder on revealed: he facility for a reported patient and bloody". In the scene, the Paramedics				
	approximately 3 fee the door to his room -There was blood or wheelchair as well a on his bed. -The blood under the -He assisted the Pal	n Resident #1, on his is under the wheel chair, and e wheelchair was "jelly like". ramedics with getting				
	Resident #1 out of th CPR. -Once Resident #1 w responder performe -With every compres "shooting" out of a h -The Paramedics ap	he wheel chair to perform was on the floor a second first				
	-The Paramedics co	ntacted their commander and compressions after one				
	07/01/20 at 9:10am i -He responded to the reported cardiac arre	e facility on 06/23/20 for a est. the scene the Paramedics				

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Division of Health Service F				FURM	APPROV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
	HAI.060149	B. WING		07/	15/2020
NAME OF PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE	<u></u>	<u> </u>
EAST TOWNE			AMITY ROAD		
	CHARLO	DTTE, NC 282	05		
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) Complet Date
D914 Continued From p	age 42	D914	······································		
from the hed facin	ig the door to his room.				
-There was blood					
	he wheel chair was				
"congealed".					
	ich blood toward the door,				
"tracks" from some					
	sponders assisted the				
	ing Resident #2 out of the				
wheel chair onto th					
	onder assisted with CPR. ession blood would shoot from				
	and pressure on the site was		~		
not stopping it.	and pressure on the site was				
	after direction from medical				
command.					
-There was an "exc	cessive amount of blood" at the				
scene.					
Telephone interviev	w with a medication aide (MA)				
on 07/07/20 at 3:48					
	ident#1's room around				
6:00am to take his	fingerstick blood sugar (FSBS)				
and administer his					
- She observed Re	sident #1 sitting in his				
	head extended back.				
wheelchair and the	Il over him, the bed, the				
	m CPR because she could not				
locate any persona	protective equipment (PPE).				
Telephone interviev	v with a second MA on				
07/07/20 at 4:10pm					
	n the second shift, 7:00pm				
-7:00am.					}
	, and the operator asked if	1			
	ator in the building and she	1 I			}
· did not know.	lla diamposia af a	ļ			1
hland barna infaction	I's diagnosis of a contagious on, the MAs did not want to				
perform CPR witho					
sion of Health Service Regulation	мсі і Ба.	<u> </u>		·····	

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		HAL060149	B. WING		07/	15/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
EAST TO	Nather			AMITY ROAD		
CASI IC	JWNE		TTE, NC 2820			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	COMPLET DATE
D914	Continued From pa	ge 43	D914			
	07/09/20 at 3:49pm -On the morning of MAs to perform CPI responders arrived. -When she arrived a approximately 8:20a not performed CPR to arrive. -The MAs were CPF Resident #1's room did not follow the en -She expected the C CPR according to th /Falls/Emergency ar Telephone interview Health Professional nurse (RN) on 07/10 -She arrived at the fi approximately 9:30a -When she question did not perform CPF	06/23/20, she instructed the R on Resident #1 until the first at the building at am, she was told the MAs had while waiting for the medics R certified and present in at the time of the incident and nergency protocol. CPR certified staff to perform				
	Summary report date -The staff member p Resident #1's cardia CPR despite the resident despite the resident for Administrator). -Staff member stated due to Resident #1's blood borne pathoge anything to protect h	d she refused to initiate CPR diagnosis of a contagious on, and she did not have				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY IPLETED
	HAL060149	8. WING		07/	/15/2020
NAME OF PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, S	TATE, ZIP CODE		
EAST TOWNE		RTH SHARON TTE, NC 2820			
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES	ID			
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D914 Continued From pa	age 44	D914		······································	
 a Registered nurse 07/10/20 at 2:15pn -Resident #1 had a venous catheter wh for his dialysis trea -He had been a pa since May 2019, ar a week on Tuesday -She did not expec findings regarding a the dialysis center of emergency, bleedir device. -The skin around th dressing. -Dialysis staff remo assessed the skin w their treatment. -The facility staff sh catheter was intact Telephone interview (PCA) on 07/13/20 -Resident #1 was ir hospital visits during -She provided care days. -He had a dialysis device "we were not allowe She was directed no by the MA. Refer to telephone in 07/13/20 at 9:30am. 	right upper chest central hich served as an access port tments. tient of the dialysis center and received treatments 3 times 7, Thursday and Saturday. It the facility to report any a resident's fistula or port to unless there was an ag or dislodgement of the ne catheter was covered with a ved the dressing and when the resident came in for rould only verify that the and not dislodged. / with a personal care aide at 9:30am revealed: n quarantine in his room due to g the month. for Resident #1 on some evice in his chest. was a medical device and ad to touch it". not to touch the dialysis device interview with a PCA on		·		

STATE FORM

Division of Health Service R	egulation			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
	HAL060149	B. WING		07/	15/2020
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS. CITY S	STATE, ZIP CODE		TOLLOLY
EAST TOWNE		TTE, NC 282			
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		т <u>г</u>
PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X6) COMPLETE DATE
D914 Continued From pa	ige 45	D914			
Refer to telephone	interview with the				
Administrator on 07	7/09/20 at 3:49pm and on				1
07/13/20 at 1:27pm					
Refer to telephone	interview with the Regional				
LHPS RN on 07/10	/20 at 9:20am.				
2. Review of Reside	ent #2's current FL2 dated				
	liagnoses included diabetes,				
. diabetic chronic kid	ney disease, end stage renal				
failure, pulmonary e	mbolism, bilateral below the				
knee amputation wi	th prosthesis, hypertension,				
	obstructive sleep apnea and				
hypertension.					-
Review of Resident	#2's Resident Register				
revealed an admiss	ion date of 03/31/20.				
Review of Resident	#2's current Care Plan dated	1			
04/04/20 revealed:					
-Resident #2 require	ed extensive assistance with				
bathing.	ed limited assistance with	1			
	eating and transferring.				
	caring and datatetring.				
a. Review of Reside	nt #2's hospital discharge				
instructions dated 0	6/29/20 at 6:03pm revealed:				
-The physician was	to be notified after he left the				
hospital for any of th	e following reasons due to				
the new dialysis por	t placement; swelling, being				
hreath more poin of	edness, chest pain, short of pain was worse, unusual				
bleeding, drainage	odor from incision or wound,				
and if temperature w	as above 101 or higher at				
any time.	-				
-Remove the dressi	ng in 48 hours and then				
shower at that time,	may leave open to air at that				
time.					
Division of Health Service Regulation		1			

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	ECONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		HAL060149	B. WING	1994	07/	15/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	TATE, ZIP CODE		

EAST TO	JVVNE		TTE, NC 282			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ai	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLE
D914	Continued From pa	ge 46	D914			
	2020 skin assessm	#2's April, May, and June ent sheets revealed there was elated to his dialysis access				
	2020 electronic Med	#2's April, May and June dication Administration Record ere was no documentation is access port.				
	revealed there was #2 having a new dia	nt #2's progress noted no documentation of Resident Ilysis port placed or nented related to his dialysis				
	07/01/20 at 12:30pn -Resident #2 had a either it had been th she was not sure. -He was one of her i medications to but n -She was not trained dialysis access ports related to signs and abnormality. -If there was bleedin and call for help. -All the residents at dialysis and dialysis the dialysis access p -The facility staff was	dialysis port in his chest, ere awhile or was brand new, residents she administered not daily. d by the facility on what the s were, or what to look for symptoms of infection or ng, she would apply pressure the facility were seen in was responsible for checking				
	revealed:	ent #2 on 07/01/20 at 3:34pm egs amputated below the				

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Division of Health Service F	Regulation			FURW	IAPPRO
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY
ŧ					
	HAL060149			07/	15/2020
AME OF PROVIDER OR SUPPLIEF	STREET A	DORESS, CITY, S	TATE, ZIP CODE		
EAST TOWNE			AMITY ROAD		
		TTE, NC 282			
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLI DATE
D914 Continued From p	age 47	D914			······································
knee due to broke	n ankles that did not heal and				
infection set in,	n ankies that did not hear and				
	ious fistulas (AVF, Is an				
abnormal connecti	ion between the artery and a				
vein, used as a dia	alysis access port) in both arms				
	resulted in a perma-cath (a				
catheter placed in	a vein closest to the atrium of				
the heart and used	in an emergency for dialysis)				
	est in September 2019.				
	vas considered only temporary.				
-He was told by the	surgeon he had one more				
option left for perm	anent dialysis port site and				
that was to place a	n AVF in his right upper chest				Ì
and on 06/29/20 he	e received the AVF in his right				
upper chest.	-				
	harge instructions for the care				
of the new AVF in h	nis right upper chest.				
	tructions included care of the				
	gns and symptoms to watch				
out for.					
-The staff did not c	heck his dialysis access ports;				
the dialysis nurse c	hecked them on Monday,				
Wednesday and Fr					
	sk to see his dialysis access				
	/F after the procedure on				
06/30/20.	avan in almostic as to the				
	arge instructions to the				
	A) when he came back to the				
	⁻ was placed on 06/29/20. Director of Resident Care				
	had a dialysis port placed in				
his left chest wall a	s the instructions stated and				ł
he told her it was n	laced in his right chest. The				
DRC left and did no	of come back				
	WF port was checked was at				
the dialysis clinic or	n 07/01/20.				
	he new incision site and the				ĺ
	check it for redness, swelling				
and drainage but he	e could notify the staff if he				
had chest pain, sho	ort of breath or increased pain.				
ion of Health Service Regulation	and the second profile.	<u></u>			<u> </u>

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Regulation			1 477 (1)	/I APPRO∖
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				e survey IPleted
HAL060149	B. WING	1941-1	07/	15/2020
R STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPL DATI
bage 48	D914			
0 at 10:15am revealed: ived dialysis through his theter placed in a vein closest to heart and used in an alysis) located in his left chest. 2 other AVFs that clotted off used so the perma-cath was ber 2019. sident #2 had an AVF placed in est which was not a normal site f the AVF in his right upper ered a "last resort" because of ally places for an AVF were ng clotted off and could not be a facility staff to check and is ports daily for swelling, or bleeding and ask Resident rmess at the sites or any I to the dialysis access ports, the facility staff to look at Resident ted in his right upper chest at day for signs of infection which selling, odor from the wound, wound, or the a fever of 100 or of a new access port the facility for signs of complication that such as, shortness of breath,				
w with Resident #2's rgeon on 07/10/20 at 11:32am				
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDENTIFICATION IDENTIFICATION IDENTIFICATION: IDENT: IDENT:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIFI A. BUILDING: HAL060149 B. WING B. WING	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: HAL060149 B. WING :R STREET ADDRESS, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205 TATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE AC CROSS-REFERENCE) page 48 D914 ew with Resident #2's Dialysis 0 at 10:15am revealed: eved with Resident #2's Dialysis 0 at 10:15am revealed: eved of laysis through his theter placed in a vein closest to heart and used in an alysis) located in his left chest. 2 other AVFs that clotted off used so the perma-cath was ber 2019. sident #2 had an AVF placed in est which was not a normal site f the AVF in his right upper ered a "last resort" because of ally places for an AVF were ng clotted off and could not be e facility staff to check and sis ports daily for swelling, or bleeding and ask Resident the facility staff to lock at Resident the facility staff to lock at Resident the facility staff to lock at Resident the in his right upper chest at day for signs of infection which selling, odor from the wound, wound, or the a fever of 100 or of a new access port the facility for signs of complication that such as, shortness of breath, creased pain. w with Resident #2's trgeon on 07/10/20 at 11:32am O4pm revealed:	KREQUENTION (KI) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER: (XI) PROVIDERSUPPLIENCLIA A BUILDING: (XI) DATA HAL060149 B. WING (ZI) IR STREET ADREES, CITY, STATE, ZIP CODE 4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205 INTERMENT OF DEFICIENCIES INTERMENT OF DEFICIENCIES INTERMENT OF DEFICIENCIES IDENTIFY NG INFORMATION) PAGE 48 D914 EW WITH Resident #2's Dialysis 0 at 10: 15am revealed: PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE ORDER'S PLAN OF CORRECTIVE ACTION

STATE FORM

2

Division of Health Service R	legulation			FURI	IAPPRO\
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	ESURVEY
AND I FAN OF OUR LEGION	IDENTIFICATION NUMBER:	A. BUILDING:	:	Сом	PLETED
	HAL060440	B. WING			
	HAL060149			07/	15/2020
NAME OF PROVIDER OR SUPPLIER			TATE, ZIP CODE		
EAST TOWNE			AMITY ROAD		
		TTE, NC 282	05		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X3) COMPLE DATE
D914 Continued From pa	age 49	D914			
	•				
port,	resort" for his dialysis access				
	left chest wall perma-cath (is				
a catheter placed t	hrough a vein into or near the				
right atrium and us	ed for dialysis in an emergency			•	
or permanent until	a device is ready to use) after				
multiple failed acce	sses were placed. The				
perma-cath was pla	aced September 2019.				
-The discharge inst	tructions were considered	1			
	Resident #2 to take back to	[
the facility.					
-The discharge inst	ructions for the surgical				
wound included sig	ns and symptoms for the staff				
	ch for which included no				
	s until the dressing was				· ·
removed.	.				
- The signs to obser	ve for included; redness,				
infection.	rainage which would indicate				
	unlaimed of an at-if shares i]
ehortness of breath	plained of or staff observed				ſ
the sight or bloeding	, chest pain, increased pain at g, 911 should be called				
because that was c	onsidered more serious				
	urgical procedure especially	}			
with Resident #2's h	history of pulmonary embolism				
and previous site fa	ilure due to clotting.				
-All the above symp	toms could happen at any				l
time within the first	48 hours after an AVF was	Í I			
placed.					
-Resident #2 was di	alyzed on Monday,				
Wednesday and Fri	days and would need for his				
dialysis access port	s to be looked at or "laid eyes	í j			
on" in between dialy	/sis days.				
 rxesident #2's perm 	na-cath had a dressing on it				
	ysis center and should be				
kept clean and dry.	o had a plane water as a				
dressing which was	so had a clear, waterproof				
which helped to prev	placed by the dialysis center				
This clear waterpro	of dressing should be				
ion of Health Service Regulation	or arosoning should be	<u> </u>			

STATEMENT OF DEFICIENCIES (X1) PROVIDERINGUENCIAN (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING (X3) DATE SURVEY HAL060149 B. WING 07/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4816 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205 CHARLOTTE, NC 28205 PROVIDERS PLAN OF CORRECTION (X4) ID SLMMARY STATEMENT OF DEFICIENCIES ID PREERX CHARLOTTE, NC 28205 PROVIDER STAN OF CORRECTION (X4) ID SLMMARY STATEMENT OF DEFICIENCIES ID PREERX RESOLATION CALC BLO IDENTIFYING WFORMATICN) PREERX TAG RESOLATION CALC BLO IDENTIFYING WFORMATICN) PREERX D914 Continued From page 50 D914 Observed for a "flat seal" to prevent water or moisture from entering the wound and causing an infection Any signs of infection or "Iffing" of the clear dressing should be reported to the physician. D914 Telephone Interview with the previous Director of Resident Care (DRC) on 07/13/20 at 12:50pm revealed: -She was an Licensed Practical Nurse (LPN) started work at the facility as the DRC on June 1, 2020. -She was an Licensed Practical Nurse (LPN) started to medication admininstrator. -She was responsible for "ge
HAL060149 B. WING O7/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4816 NORTH SHARON AMITY MOAD EAST TOWNE CHARLOTTE, NC 28205 CHARLOTTE, NC 28205 (04) D (EACH DERICENCY MUST BE PRECIDEDED BY FULL TAG D PREFX PROVIDER'S PLAN OF CORRECTION (EACH DERICENCY MUST BE PRECIDEDED BY FULL TAG D PREFX CORRECTIVE ACTION BHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CORRECTIVE DEFICIENCY D914 Continued From page 50 D914 D914 D14 D14 Observed for a "flat seal" to prevent water or moisture from entering the wound and causing an infaction. Any signs of infection or "lifting" of the clear dressing should be reported to the physician. D914 Telephone Interview with the previous Director of Resident Care (DRC) on 07/13/20 at 12:50pm revealed: -She was an Licensed Practical Nurse (LPN) started work at the facility as the DRC on June 1, 2020. -She did not receive direction about her DRC duties from the Administrator. -She was responsible for "getting the staff together" related to medication administration and "putting out little fires" related to resident and staff complaints. -She did not know Resident #2 had a dialysis access port on the left upper chest. -On 06/30/20, the Regionel LHPS Nurse informed her of Resident #2 new surgical left upper chest dialysis access port and to confirm the correct site as well as giving her the instructions on the
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her of Resident #2's new surgical left upper chest dialysis access port and to confirm the correct site as well as giving her the instructions on the
site as well as giving her the instructions on the
care after the procedure to "read" to Resident #2
-She took the copy of the instructions to Resident #2 and gave them to him to check his own sight.
-Resident #2 informed her that the new access
port was completed on the right upper chest and he had an older perma-cath on the left upper
chest. -She informed the Administrator and the Regional
LHPS nurse the correct site was on the right
upper chest for the new surgical site.
-When she informed the Administrator and the Regional LHPS nurse, she was told "they would handle it"
-She did not check his site again.
-There was no training for the facility staff related
to what the dialysis access ports were, where

STATE FORM

ATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
	HAL060149	B. WING		07/	15/2020
ME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
AST TOWNE	4815 NOF	TH SHARON	AMITY ROAD		
		ITE, NC 282			
REFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D914 Continued From p	age 51	D914			
for a fresh dialysis -The instruction to and the Regional I because the "dialy -She felt it was her access ports, the A LHPS nurse said th Telephone intervier 07/14/20 at 1:30pn -On 06/30/20, was about Resident #2" -Resident #2 made arrangements to g -Resident #2 made arrangements to g -Resident #2 made and transportation -She did not consid as "orders" becaus -The DRC was res #2's surgical site an informed her the si wrong side on the i -She did not instruct the dialysis access that. -It could be a possi- have a complication weekends. Refer to telephone Care Assistant (PC Refer to telephone on 07/13/20 at 9:30	w with the Administrator on n revealed: the first time she was informed s dialysis access port. his own appointments and et to and from dialysis. his own surgical appointment arrangements. ler the discharge instructions e the "were not signed". ponsible for checking Resident nd did so on 06/30/20 and te was documented on the nstructions. et the staff to check or monitor port because "dialysis" did bility for a dialysis resident to n after dialysis and on the interview with the Personal A) on 07/13/20 at 9:14am. interview with a second PCA am.				

	NT OF DEFICIENCIES I OF CORRECTION '	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		CONSTRUCTION		E SURVEY PLETED
		HAL060149	B. WING		07/	15/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
EAST TO	OWNE		RTH SHARON TTE, NC 2820	AMITY ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF {EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
D914	Continued From pa	nge 52	D914		, 	
	Administrator on 07 07/13/20 at 1:27pm	7/09/20 at 3:49pm and on 1.				
	Refer to telephone LHPS RN on 07/10	interview with the Regional /20 at 9:20am,				
	04/01/20 revealed a positive airway pres pressure on a conti airways continuous help keeping their a night as tolerated a	ent #2's current FL2 dated an order for continuous ssure (CPAP, applies mild air inuous basis to keep the ly open in people who need airway unobstructed) wear at nd remove in the morning, s on and in place while resident				
	Professional suppo	:#2's Licensed Health rt (LHPS) dated 04/22/20 #2's tasks included monitoring				
	revealed: -An entry to wear C and remove in the r on and in place whil documented as adm	#2's May 2020 eMAR PAP at bedtime as tolerated norning, (make sure CPAP is le resident is asleep), ninistered 05/01/20- 05/31/20, ries to clean or replace CPAP or tubing/mask,				
	revealed: -An entry to wear Ci and remove in the r on and in place whil documented as adm	#2's June 2020 eMAR PAP at bedtime as tolerated norning, (make sure CPAP is le resident is asleep), ninistered 06/01/20- 06/30/20. ries to clean or replace CPAP or tubing/mask.				
	Review of Resident					

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION		E SURVEY IPLETED
·····		HAL060149 B. WING		07/	15/2020	
NAME OF	PROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, S	TATE, ZIP CODE		
EAST TO	ΰWNE	4815 NO	RTH SHARON	AMITY ROAD		
	,	CHARLO	TTE, NC 2820)5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(XS) COMPLET DATE
D914	Continued From pa	ge 53	D914			
	mask and tubing fo -On 07/01/20 at 1:6 resident refused to mask hurting his no -Resident also state faced CPAP mask i reported to physicia Interview with Resid revealed: -He did not wear his the last 2-3 weeks it the machine, filter, f cleaned or replaced -He asked the staff was congested abo -About 2 months ag him a full-face mash his nose and was un -He still did not have -He informed the sta (07/01/20) about ne the machine was still Observation of Resid 07/01/20 at 3:40pm -There was a nose in the CPAP machine. -The machine was of	ed the he prefers to use a full instead, health care concern in. dent #2 on 07/01/20 at 3:34pm is CPAP machine at night for because was congested and cubing and mask had not been i. to clean it for him when he ut 2-3 weeks ago. o he asked the MA to order k because the nose mask hurt incomfortable. The full face mask. aff again earlier this morning eding the full face mask and il dirty. dent #2's CPAP machine on revealed: mask with tubing attached to fusty and dirty. d dried brown and clear flaky				
	07/09/20 at 2:49pm -Most of the residen	ts had their CPAPs on when 🍴				
	she administered the -"I was not asked to -We were instructed					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		E SURVEY
	,		A DOLEDING,	,		
		HAL060149	B. WING	**************************************	07/	15/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		Terrerer
EAST TO	MANE.	4815 NO	RTH SHARON	AMITY ROAD		
	~ * * * * * * * * * * * * * * * * * * *	CHARLO	TTE, NC 282	05		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF	CORRECTION	(X5)
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	THE APPROPRIATE	COMPLE DATE
	Captinued Fram no			DEFICIENC	(Y)	
0314	Continued From pa	IGE 54	D914			
	and it broke.					
		icted on how to clean a CPAP				
	machine.	now to clean a CPAP machine,				
	-She knew how to a	assist in putting on because				
	she was trained how	w to do so on her other job.				
	Telephone interview	v with Administrator on				1
	07/09/20 at 3:49pm	revealed:				
		cked off all staff on CPAP				
	administration and					
		w to determine if the CPAP				
		ly, there was airflow and it	-			
	was applied propert	be cleaned monthly.				
		Coordinator (RCC) ordered	1			
		CPAP machine when				
:	needed.					
	Telephone interview	with the Regional Licensed				
	Health Professional	Support (LHPS) Nurse on				
	07/10/20 at 9:20am	revealed;				
		staff competencies for the				
		d; observation of the resident				
	applying the mask, I	to report issues with the CPAP				
	machine/mask to th	e physician and to document				
	The MAs was place	d on the resident or taken off.				
	mask on the regider	ponsible for putting the CPAP at or to assist the resident if				
		with ability to put it on or a				
	adjustment to make					
		consible for cleaning the water				
:		distilled water and left out to				
	dry, and replacing th	ne tubing/mask as needed.				
:	-If a resident had res	spiratory symptoms such as				
	congestion, the mas	k should be cleaned daily to				
	avoid the increased	respiratory issues.	•			-
	-If the CPAP machin	e/tubing/mask was not				
	cleaned, it would col	mpromise the delivery of the				
	air to the resident.					1

Division of Health Service F	Regulation			FORM	APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
	HAL060149	B. WING		07/	15/2020
NAME OF PROVIDER OR SUPPLIER	STREET A	DRESS CITY S	TATE, ZIP CODE		
EAST TOWNE		TTE, NC 282			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE /	SHOULD BE	(X5) COMPLETE DATE
D914 Continued From p	age 55	D914	DEFICIENCY)		
i		0411			
Telenhone intervie	w with a Durable Medical				
	company on 07/15/20 at				1
10:00am revealed:					
-A CPAP machine	should be cleaned externally				
daily with a warm o	amp cloth.	-			
- The tubing should	be changed every 3 months,	1			
the filler every 2 w	eeks, a full mask every month, / 2 weeks and the water				
chamber every 6 n					
	bing should be cleaned daily				
with a warm soapy	water and allowed to air dry	Í			
especially after bei	ng sick to prevent bacteria				
from entering your	lungs.	ļ			
(PCA) on 07/13/20 -She was a PCA or personal care to th	w with the personal care aide at 9:14am revealed: n first shift and provided e residents on her assignment				
sheet.	• • • • • • • • •				
and ports from a fa	formation regarding dialysis mily member who had a port.				
-Sne knew the com	mon problems of a port were				
-She had not had a	lite and dislodgement, iny specific training regarding				
the care of ports or	fistulas from the facility.				
-She performed ski	in assessments on the				
i residents on their s i week.	hower days, 2 to 3 times a				
-She recorded any	skin tears, bruising, redness				
or anything out of the	ne ordinary on a Skin and				
Body Observation s					
sheet to the MA for	Skin and Body Observation				
-The sheets were b	rought to the Director of				
Resident Care (DR	C) for review.				
Telephone interview	v with a second PCA on				
07/13/20 at 9:30am	revealed:				
	lents with fistulas. Most of				
vision of Health Service Regulation					<u> </u>

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				e survey Pleted
		HAL060149	B. WING		07/	15/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
EAST TO	OWNE		RTH SHARON TTE, NC 282			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	DEPERTION	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
D914	Continued From pa	ge 56	D914	**************************************		
	up. -She did not know a because they were -She knew that whe the resident had to new site." That hap hers. -The previous DRC body observations of bruises, bumps and -She would treat a f type of body observ -She knew to look fe around the site. -She was not traine the care of ports or Telephone interview 9:36am revealed: -She knew that an it treatments could ha -She did not know w -She did not know w arise with a resident -She had not received on the care of reside Telephone interview 07/09/20 at 3:49pm revealed:	en a fistula became "clogged" go to the hospital and "get a pened to a family member of trained the staff in completing on shower days to look for anything out of the ordinary, istula or a port with the same ation training. or bleeding, swelling or pus d by the facility specifically on fistulas. with an MA on 07/13/20 at individual who had dialysis ve a port in their chest. /hat a fistula was, f any resident in the facility /hat type of problems could who had a port or a fistula. ed any training at the facility ents with ports or fistulas. with the Administrator on and on 07/13/20 at 1:27pm it to the dialysis center were				
	-The facility staff we any care (for fistula -She and the previou	re not supposed to provide				

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Division of Health Service R	egulation			FURI	APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		E SURVEY
	1	A. BUILDING:		COM	IPLETED
	HAL060149	B. WING		07/	/15/2020
NAME OF PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	STATE, ZIP CODE		TOLLORO
EAST TOWNE			AMITY ROAD		
	CHARLO	TTE, NC 282			
PREFIX (EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
D914 Continued From pa	ge 57	D914	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
 The staff should of drainage and swelli -Fistulas and perma catheters) were obsithe rest of the body There was no train fistulas and perma Telephone interview on 07/10/20 at 9:20 She was the previor May 2020. She trained the PC of the skin and body day. If a resident preferrindependently, the Fithe bedroom for safibefore the resident of the bedroom for safibefore the resident of The PCAs were trained before the resident of report to their super -As the DRC she wo Skin Observation shi -MAs and PCAs hav or perma catheters. If the staff observed complained of pain, dialysis center. If the resident had if staff should put pres -She did not include 	pserve the skin for redness, ng. a catheters (central venous served in the same manner as ing on the education of catheters she was aware of. with the Regional LHPS RN am revealed: bus DRC from July 2019 to As on the proper observation y on their resident's shower PCA was instructed to stay in ety and observe the body dressed. ined to observe any visible kin breakdown or any n the shower sheet and visor. build then review the Body and teets left in her box. The no responsibility for fistulas t bleeding or the resident they would contact the bleeding from the site, the sure on the site and call 911. the care of fistulas or perma S assessment or the care	D914			
The facility failed to neglect for 2 of 5 sar #1) who had a"Full 0	ensure residents were free of mpled residents (Resident code" and did not receive suscitation (CPR) from the				

Division of Health Service R TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
ND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			2	0.01/1		
	HAL060149	B. WING		07/	5/2020	
AME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE		UI AUAU	
			N AMITY ROAD			
AST TOWNE		TTE, NC 28				
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
RÉFIX (EACH DEFICIENC) TAG REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF	HOULD BE	COMPL	
	······································	IAG	DEFICIENCY)	PROPRIATE	DAT	
D914 Continued From pa	ge 58	D914	and the second se			
facilty staff, when h	e was in cardiac arrest, per					
the facility emerger	cy policy and was pronounced					
dead shortly after the	e first responders arrived,					
and who had a cen	ral venous catheter as a port					
for dialysis treatme	nt without specific staff training					
on observation and	reporting possible side					
	2 who had received a AVF				ĺ	
(dialysis port) on 06	/30/20 and could not use his					
CPAP machine for :	2-3 weeks because of an		1			
upper respiratory of	omplaint and the CPAP					
	eaned. This failure resulted in					
· Violation.	ch constitutes a Type A1					
			G.S. 131D-25 Implementation G.S. 131D-25 Implementation			
The facility provided	a plan of protection in			in a state of all so at		
accordance with G.	S, 131 D-34 on 07/14/20.		Resposibility for implementing the provisions of the with the administrator of the facility. Each facility s appropriate training to staff to implement the decl.	shall provide		
CORRECTION DAT	E FOR THE TYPE A1		Residents rights included in G.S. 131D-21			
	NOT EXCEED AUGUST 14,		Staff were trained 6/23/2020 and 6/30/2020 on the	policy and		
2020.	NOT EXOLED X00001 14,		procedure of how to respond in an emergency situal Inservice on correct Medication Administration inclu	ation. Jaina terminology		
			for all MA on 7/17/2020 Immediate inservice will be held on Residents Righ			
D980 G.S. § 131D-25 Im	plementation	D980	LHPS nurse			
-		19900	Staff were trained on 7/22/2020 on the difference o unestablished fistulas and what to look for by Collin	of an established/		
G.S. 131D-25 Imple	mentation		DRC/RCC will review FL2 at time of admission for and process accordingly,documentalon will be add	DME equipment ed to the EMAR		
Responsibility for im	plementing the provisions of		to remind staff to complete task All charts will be reviewed by RCC/ED to ensure co	mpliance completed		
this Article shall rest	with the administrator of the		7/20/2020 and 7/21/2020 Training at time of hire on the difference of establis			
facility. Each facility	shall provide appropriate		unestablished fitulas and what to look for			
training to staff to in	plement the declaration of		DRC/RCC will include on the 3050R under other ta entities (example:ports, shunts, catheters,CPAP) u	sk to ensure external sage to ensure		
residents' rights incl	uded in G.S. 131D-21.		external devices will be managed effectively.			
This Rule is not me	t as evidenced by:					
TYPE A1 VIOLATIO						
Based on recomme	ndations, interviews, and					
record reviews, the	Administrator failed to ensure		Facility will be in compliance by 8/14/2020			
the management. or	perations, and policies of the			ŀ		
facility were impleme	ented and rules were					
maintained for pore	nal care and supervision,					

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	alth Service R					APPROV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL060149	B. <u>W</u> ING		07/	15/2020
NAME OF PROVID	ER OR SUPPLIER	STREET A	DORESS, CITY, S	TATE, ZIP CODE		
EAST TOWNE				AMITY ROAD		
			TTE, NC 282	05		
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLE DATE
D980 Cont	inued From pa	age 59	D980			
resid	ent rights, and	medication administration.				
The	indings are:					
07/0 -She dialys relate abno -The dialys acces	I/20 at 12:30p was not traine sis access por ed to signs and rmality. facility staff was sis access por ss ports at all.	rst medication aide (MA) on m revealed: ed by the facility on what the ts were, or what to look for d symptoms of infection or as not allowed to touch the ts and she did not check the w with a second MA on				
07/13 -She -She who i -She	0/20 at 9:36am did not know v did not know o nad a fistula. had not receiv	revealed: what a fistula was. of any resident in the facility red any training at the facility ents with ports or fistulas.				
aide (-She perso sheet -She the ca (AVF, artery	PCA) on 07/1 was a PCA on nal care to the had not had a are of dialysis is an abnorm	with a first personal care 3/20 at 9:14am revealed: first shift and provided residents on her assignment ny specific training regarding ports or Arteriovenous Fistula al connection between the sed as a dialysis access port)				
07/13 -She dialys -She	/20 at 9:30am provided care is device in his	for Resident #1 and he had a s chest. d by the facility specifically on				

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	HAL.060149	B. WING		07/	15/2020
AME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
AST TOWNE		RTH SHARON TTE, NC 2820	AMITY ROAD		
REFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION}	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D980 Continued From pa	age 60	D980			
on 07/10/20 at 9:20 -MAs and PCAs has or perma catheters -She did not includ catheters on an LH since it was not a t Telephone interview Resident Care (DR revealed: -She did not receiv duties from the Adr -There was no train to what the dialysis care instructions, n access port instruc -The instruction to and the Regional L because the "dialysis Telephone interview revealed: -She did not know n	ave no responsibility for fistulas e the care of fistulas or prma IPS assessment of a resident ask. w with the previous Director of (C) on 07/13/20 at 12:50pm e direction about her DRC ministrator. hing for the facility staff related access ports were, located or ot even for a fresh dialysis tion. the staff, per the Administrator HPS nurse was to "not touch", sis" handled those. w a MA on 07/07/20 at 3:48pm where to find PPE.				
Telephone interview 07/07/20 at 4:10pm -She was not award	PE might have been in the out she did not check. v with a second MA on n revealed: ∋ if there was a defibrillator in				
	f there was PPE on the he medication room.				
at 2:33pm revealed	v with a sixth MA on 07/08/20 l everyone at the facility knew e residents were not here for administered.				
Telephone interview	v with a seventh MA on				

Division of Health Service F STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	747017	HAL060149	B. WING		07/	07/15/2020	
NAME OF	PROVIDER OR SUPPLIER	STREETA	DORESS, CITY, S	TATE, ZIP CODE		12 Workshop (1977)	
	NAME	4815 NO	RTH SHARON	AMITY ROAD			
EAST TO	JWINE		OTTE, NC 2820				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
D980	Continued From pa	age 61	D980				
	medications are du administer them.	m revealed: lot in the building when his le they were not required to lity policy for missed					
	07/10/20 at 9:30am -She knew Resider 2L NC as needed. -She knew Resider and it was used for	nt #5 had an order for oxygen nt #5 had oxygen in his room SOB. cumented the administration of					
	07/09/20 at 3:49pm revealed: -She was the Admin November 2019. -The facility Market the facility. -The Marketer did r -The Administrator FL2s for the new ac not. -The staff were cap acuity residents tha but they needed mo -The DRC had take the company and w day 2 or 3 times we -The Regional LHP completing staff tra could not recall any or how to observe/r ports. -There were 5 dialy	n a new corporate role with ras in the facility 1 or 2 hours a					

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Division of Health Service R	(X1) PROVIDER/SUPPLIER/CLIA	(¥2) MUUTIDI	Ε ΛΛΙΟΤΟΙΙΑΤΙΑΝ			
ND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	HAL060149	B. WING				
AME OF PROVIDER OR SUPPLIER]		07/	15/2020	
			TATE, ZIP CODE I AMITY ROAD			
AST TOWNE		TTE, NC 282				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE	(X5) Comple Date	
D980 Continued From pa	age 62	D980	Name			
the hospital on 06/3 surgical wound dia -She considered th the hospital instruc -The staff were not fistulas or ports). -There was no form fistulas and perma -She did not know i their morning media received dialysis tre -She could not expl administer medicat resident was at dial -She did not know i the eMARs as need -She was in charge the facility.	29/20 he had a procedure for a lysis port. le discharge instructions from tions and not an order, to provide any care (for nal training on the education of catheters she was aware of, residents had not received cations on the days they eatment. lain why the MAs did not ions 3 times a week when a lysis. MA were not documenting on ded medications, of day to day operations in					
07/14/20 at 12:45pr she was transferred	~					
Non-compliance wa rule areas at the vic	as identified in the following plation level:					
facility failed to resp accordance with the and procedures for (Resident #1) who t venous catheter tha required an immedi	reviews and interviews, the bond immediately and in e facility's established policy 1 of 5 sampled residents had bleeding from a central at became dislodged which ate emergency response. 10A NCAC 13F .0901 (c) e A1 Violation)].					
facility failed to ensu neglect for 2 of 5 sa	reviews and interviews, the are residents were free of impled residents related to ho had a physician's order for					

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Division of Health Service F		-		FURN	IAPPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING;			(X3) DATE SURVEY COMPLETED	
	HAL060149	B. WING	07/	07/15/2020		
NAME OF PROVIDER OR SUPPLIER STREET ADD		DDRE\$S, CITY, STATE, ZIP CODE		07/13/2020		
SAST TOWNE			AMITY ROAD			
		TTE, NC 282				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE	(X5) COMPLETI DATE	
D980 Continued From p	age 63	D980				
 pulmonary resusci arrest due to blood catheter that was of who had received Fistula (AVF dialys discharge instructi and tubing due to of providing a full fact Tag 914, GS 131D A1 Violation)]. 3. Based on record facility failed to addr ordered by a licens 2 of 5 sampled res for a contagious bli hypertension, a blo potassium, fast act before meals and of with parameters (R blood pressure me checks with param prevent blood clots blood sugars and n phosphorus levels (Resident #2). [Ref 	is and did not receive cardio tation (CPR) when in cardiac l loss from a central venous dislodged; and a resident (#2) a new surgical Arteriovenous is port) on 06/30/20 with ons and his CPAP machine unclean conditions and not e mask (Resident #2). Refer to -21 (4) Resident Rights (Type I reviews and interviews, the ninister medications as ted prescribing practitioner for idents, related to medications ood borne pathogen, nod thinner, elevated levels of ting insulin to lower blood sugar faily blood pressure checks tesident #1); and related to dications and blood pressure eters, medications used to , medications used to lower hedications used to lower high in patients on dialysis er to Tag 0358 10A NCAC 13F n Administration (Type A2					
for the overall mana supervision and op- resulted in staff uns in the facility to resp situation and not ini full code dialysis re- dialysis port with ex	ailed to ensure responsibility agement, administration, eration of the facility which sure where to locate the PPE bond to an emergency tlating CPR to Resident #1 a sident, who had dislodged his tensive bleeding and death					
occurred, Resident slon of Health Service Regulation	#2 who had a emergency					

Division of Health Service R				FUNIA	IAPPROV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED 07/15/2020		
	HAL060149	B. WING			
NAME OF PROVIDER OR SUPPLIER STREET AD		DDRESS, CITY, STATE, ZIP CODE		01710/2040	
EAST TOWNE			N AMITY ROAD		
		TTE, NC 282			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ulo be	(X8) Comple Date
D980 Continued From pa	ige 64	D980		BIAMA	
procedure to place	a new surgical wound dialysis				
port with discharge	instructions to monitor and				
observed the surgic	al site while staff were not				
trained or instructed	1 on what to observe or				
monitor; medicatior	is not administered to				
Resident #1 and Re	esident #2 on dialysis days				
which included insu	llin, autoimmune medications medication for multiple days				Į
without informing th	e physician or the dialysis				
center: and oxygen	not documented on the				
administration med	cation record for Resident #5				
who had two recent					
respiratory failure. 1	This failure resulted in serious				
neglect which const	itutes a Type A1 Violation.				
The facility provided accordance with G.	a plan of protection in S. 131 D-34 on 07/14/20.				
:	E FOR THE TYPE A1				
VIOLATION SHALL 2020.	NOT EXCEED AUGUST 14,				
					ł
:					
	1				
1					
ion of Health Service Regulation	······				