Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060158	A. BUILDING: _____ B. WING _____	C 11/12/2020

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

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a COVID-19 focused infection control survey and a state involved complaint investigation survey with onsite visits on 11/04/20, 11/05/20, 11/09/20, 11/11/20 and 11/12/20, and a desk review on 11/06/20 and 11/10/20, with an exit conference on 11/12/20.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure staff provided supervision for 1 of 5 sampled residents, (Resident #5), as related to staff not ensuring a resident, who resided in the Special Care Unit (SCU), was supervised while ambulating, which led to a fall and hospitalization. The findings are: Review of Resident #5's FL2 dated 06/26/20 revealed: -Diagnoses included Alzheimer's dementia, hypertension, dyslipidemia, depression, and gastroesophageal reflux disease. -Resident #5's current recommended level of	D 269	10A NCAC 13F .0901 Personal Care and Supervision The staff member was interviewed as well as other staff and cameras reviewed. A regroup message by e-mail went out to all staff regarding the importance of personal care and supervision of all residents including observation and escorting requirements along with the mandatory review by Clinical team through daily staff assigments 24 hour shift report identifying and adhering to the specific needs of the resident. A fall prevention program was implimented and a leaf on the resident door identifying them Cont...	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Lydia Workman 12/22/20

Karen M. Polce Reviewed and acknowledged 01/28/21

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D 269	Continued From page 1 care was the Special Care Unit (SCU). -There was no documentation of ambulation status on the FL2. Review of Resident #5's Special Care Unit Profile dated 05/20/20 revealed she ambulated with the assistance of a cane. Review of Resident #5's Care Plan signed by the physician on 05/26/20 revealed she ambulated independently with the assistance of a cane. Review of Resident #5's Licensed Health Professional Support (LHPS) evaluation on 10/01/20 revealed: -Resident #5 required reminders from staff for activities of daily living (ADLs) and use of her cane during ambulation. -Staff continued to follow up on Resident #5's care needs, including reminders to use her cane when ambulating. Review of the facility's surveillance video dated 11/06/20 between 8:35pm and 9:00pm revealed:. -At 8:41pm, a staff member was at the concierge desk and another staff member was leaning on the wall in the lobby. -At 8:45pm, a third staff member exited the SCU with Resident #5 walking approximately 6-8 feet behind her, without a cane. -Resident #5 waved to the staff at the concierge desk, as she walked through the doors at the main entrance of the facility, into the parking lot. -Resident #5 ambulated without an assistive device, or a staff person in close proximity for hands on assistance. -At 8:46pm, Resident #5 continued to follow the staff member as staff approached a vehicle in the parking lot. The resident was observed 6-8 feet behind the staff member and fell onto the ground	D 269	10A NCAC 13F .0901 - cont.: As a fall risk was sent out through regroup messaging to all team members and leaves posted at resident doors who were care planned to be a fall risk. 1 to 1 conversations were completed @ shift over a 24 hour period to ensure Clinical Staff understood the responsibilites and where they have been trained to look for assistive and adaptive equipment based on the individual needs of the residents This was implemented through clinical team leaders RCD + RCC and ED. 11/12/20 + 11/13/20 A monthly staff meeting was held on 11-19-20 for all staff w/ a separate clinical meeting held to review the falls program, the requirements of supervision and escorting of residents. CNA assignments and shift report was reviewed to include infection control, Covid etc. The clinical team leaders RCD + RCC ED + pertinent Mgmt team lead the meeting. 11/19/20	

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D 269	Continued From page 2 in the parking lot. -The video surveillance did not extend into the parking lot, so the images of the fall were dark and shadowy. -The third staff member, the personal care aide (PCA) in the SCU who had just exited the building, re-entered the facility and motioned for the staff to provide assistance. -There was no video surveillance showing the staff assessing the resident in the parking lot. -At 8:57pm, 2 staff members provided hands-on assistance to Resident #5 as they escorted her into the front lobby of the facility. -The resident was able to bear weight on her left leg while walking back into the building. -Her right hand and fingers were bandaged and the left pant leg was raised exposing her left knee. -Resident #5 was assisted to a bench and waited for the Emergency Medical Services (EMS) to arrive. -At 9:05pm, Emergency Medical Services (EMS) arrived and after assessing Resident #5 they transported her to the hospital. Review of the EMS report dated 11/06/20 revealed: -Medics were dispatched to the facility for a fall on 11/06/20 at 8:57pm and arrived at 9:05pm. -Upon arrival to the facility, Medics observed Resident #5 sitting on a bench in the lobby. -Staff stated the resident had a witnessed fall in the parking lot, fell to her knees, attempted to break her fall with her hands and hit her head on the ground. -Resident #5 had a hematoma to the right side of her forehead with no loss of consciousness. -She had a laceration to the pointer finger of her right hand that had been bandaged, the middle finger of the right hand was swollen and there	D 269	The RCD-RCC developed best practices providing 3 areas staff can review for assistive devices - 24 hour report, the communication book and the CNA intouch system to include daily assignments. Completed and implemented	11/19/20 11/24/20

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D 269	Continued From page 3 was a contusion to the left knee. -Resident #5 complained of pain to her left knee and was transported to the hospital. Review of Resident #5's hospital discharge summary dated 11/09/20 revealed: -Resident #5,with a history of dementia, had a witnessed fall at her facility on 11/06/20. -She had a fracture of the left knee, a fracture of the third and fourth fingers of the right hand and a hematoma on the right side of the forehead. -She was experiencing gait instability and was placed in a knee mobilizer due to the left knee fracture. -She was admitted for further evaluation and management and thr recommended level of care, post discharge from the hospital, was a rehabilitation facility. Interview with a PCA on 11/09/20 at 4:48pm revealed: -On 11/06/20, about 8:45pm, she was going to her car in the parking lot. -Resident #5 was awake pacing in the halls. -Resident #5 liked to walk and staff would take her out of the SCU at times and walk with her throughout the building. -That evening, she allowed Resident #5 to accompany her outside to the parking lot while she went to her car. -Resident #5 was behind her as they left the building and she did not know what caused the fall. Telephone interview with a medication aide (MA) on 11/10/20 at 9:40am revealed: -She worked first shift in the SCU and the Assisted Living community. -Resident #5 became agitated at times and the staff would walk her around the facility.	D 269	In the 11/12/20 discussions and messages as well as the 11/19/20 staff mtg it was reiterated that residents should not go out after dark when staff are supervising and all walking outside of memory care requires constant supervision. This was completed by clinical team leaders, RCD, RCC & ED 11/19/20 When a resident is exhibiting behaviors that are outside of normal behaviors or require intervention or there is cause or concern for the residents safety the RCD + RCC (clinical team leaders) expressed in retraining staff to contact the RCD, RCC or clinical on call and the physician and family would be contacted. 11/19/20	11/12/20

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D 269	Continued From page 4 Telephone interview with another MA on 11/11/20 at 2:00pm revealed: -She was the MA responsible for the Assisted Living community and the SCU on 11/06/20. -The MA in the SCU was ending her shift and and she was receiving report and taking the keys to the medication cart. -While they were counting the medications, the PCA told the MA she was going to her car in the parking lot and taking Resident #5 with her. -Shortly thereafter, the PCA came back into the building and said Resident #5 had fallen. -When staff approached the resident outside, she was sitting down in the parking lot with one shoe off. -With the help of staff, Resident #5 was assisted back into the building and sat on a bench in the lobby. -EMS was contacted and the RCC was informed of the incident. Telephone interview with a PCA on 11/12/20 at 1:35pm revealed: -She was working the night Resident #5 fell in the parking lot. -She did not witness Resident #5's fall. -She was standing at the front desk when the fall occurred, turning her equipment in to the Concierge at the end of her shift. -She recalled a co-worker coming into the facility stating Resident #5 had fallen in the parking lot. -She had not worked in the SCU recently, but she recalled Resident #5 never sat still and frequently paced the halls without her cane. -She did not recall Resident #5 using a cane when walking. Telephone interview with Resident #5's Responsible Party (RP) on 11/12/20 at 4:11pm	D 269		

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D 269	Continued From page 5 revealed: -The RP received a telephone call on 11/06/20 around 8:45pm from the Resident Care Coordinator (RCC) stating Resident #5 had fallen in the facility's parking lot. -The RCC reported Resident #5 was walking in the parking lot with staff to look for Resident #5's car. -The RP was never informed the staff were taking Resident #5 out of the facility to walk. -She would never give permission for Resident #5 to walk in the facility's parking lot at night. -The fall caused Resident #5 to suffer a left knee fracture and fractured fingers in the right hand. -Resident #5 was transferred from the hospital to a rehabilitation facility for occupational and physical therapy due to her injuries. -She was learning to eat with her left hand and to ambulate with a leg immobilizer and a rolling walker that included a device for arm support. -Since the fall, and due to Resident #5's cognitive issues, she required 24-hour supervision because she could not remember to call for help when she needed to get up or go to the bathroom. -Prior to the fall, Resident #5 required a cane for ambulation. -Resident #5 used a cane since her first day of admission in 2019. Interview with the RCC on 11/12/20 at 11:18am revealed: -She was aware Resident #5 fell outside of the facility on the evening of 11/06/20. -She obtained a statement from the staff involved and created the incident report. -She had not seen the video surveillance revealing the incident that evening. -Staff were not allowed to take residents outside in the dark for a walk. -Outside walks were only allowed in the daytime	D 269		

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D 269	Continued From page 6 with staff assistance. -Resident #5 had an order to ambulate with the assistance of a cane, and the staff should be reminding her to use the cane when walking. -It was a "poor judgement call" for the staff person who took Resident #5 outside the facility at night from the SCU. Interview with the Director of Resident Care (DRC) on 11/12/20 at 9:30am revealed: -Resident #5 had dementia and was in the SCU. -Resident #5 would became agitated at times. -Staff were allowed to take residents outside for a walk, however it was prohibited at night. -The RCC contacted her on 11/06/20 regarding Resident #5 falling outside the facility. -The RCC told her a staff person had taken Resident #5 outside to her car. -The RCC said Resident #5 fell and hit her knee, hand, and head while she was outside the facility. -The RCC said Resident #5 was bleeding from her hand and knee and 911 was called. -She had not reviewed the video footage to observe the incident on 11/06/20 involving Resident #5. -She did not know Resident #5 was not in the eyesight of staff upon leaving the facility. -She did not know Resident #5 was not ambulating with a cane upon leaving the building. -Staff were to walk with the residents when outside of the building and ensure that assistive devices were always present. Interview with the Administrator on 11/12/20 at 9:45am revealed: -It was reported to her Resident #5 went outside with staff on the evening of 11/06/20. -She was informed by the DRC Resident #5 had a fall while outside the facility on 11/06/20. -She reviewed video surveillance and realized	D 269		

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D 269	Continued From page 7 Resident #5 did not have her cane while walking. -She expected staff to walk with the resident and not allow the resident to follow six feet behind them, "once the fall started, staff could not have seen it." Based on interviews and record reviews it was determined Resident #5 was not interviewable. The facility failed to provide supervision for 1 of 5 sampled residents (Resident #5), with a history of dementia, who was allowed to walk through the facility and exit through the front door after dark without her cane, and subsequently fell in the parking lot, sustaining fractures to her knee and hand, and a hematoma on her forehead. These injuries resulted in serious physical harm and injury and serious neglect which constitutes a Type A1 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on November 12, 2020 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 12, 2020.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION	D 273	10A NCAC 13F .0902(b) Healthcare RCD, RCC and/or designated Clinical staff will review and sign off orders weekly to ensure timely implementation and follow up of orders received. 11/24/20	

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D 273	Continued From page 8 Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up with the licensed practitioner for 1 of 3 sampled residents (Resident #1) related to a physical therapy (PT) referral and notification of weight loss. The findings are: Review of Resident #1's current FL2 dated 10/14/20 revealed diagnoses included seizure activity. Review of Resident #1's hospital discharge summary dated 10/14/20 revealed diagnoses included major neurocognitive disorder, insomnia, chronic pain, advanced dementia. a. Review of Resident #1's current FL2 dated 10/14/20 revealed the resident was ambulatory and required no assistive devices. Review of Resident #1's care plan dated 08/12/20 revealed the resident was independent with ambulation and transfers. Review of an incident report dated 09/27/20 at 6:30am revealed Resident #1 had an unwitnessed fall, the resident was found on the floor during rounds, there were no documented injuries. Review of Resident #1's hospital discharge summary dated 10/14/20 revealed: -Resident #1 was admitted for seizure like activity. -There were PT consultation notes documenting Resident #1 was evaluated by the physical therapy team. -PT recommended the resident would benefit	D 273	See pg. 8	

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D 273	Continued From page 9 from continued skilled PT to address deficits in order to approve functional mobility and safety. -The treatment diagnosis was documented as unsteadiness on feet. -Treatments planned included balance training, bed mobility training, gait training, therapeutic activities and exercises. - The plan included PT three times per week for two weeks. Review of Resident #1's record revealed there was no order for physical therapy and no documentation the primary care provider (PCP) was notified about the physical therapy recommendation. Review of Resident #1's incident reports revealed: -There was an incident report dated 10/21/20 at 1:15pm documenting Resident #1 had an unwitnessed fall, she was found on the floor after tripping over a sweater; there were no documented injuries. -There was an incident report dated 10/25/20 at 12:37pm documenting Resident #1 had a witnessed fall, she lost her balance while leaving her chair after eating lunch; there were no documented injuries. -There was an incident report dated 11/04/20 at 10:15am documenting Resident #1 had a witnessed fall, she lost her balance while attempting to stand, hit her head and was sent to the emergency room. Interview with the Resident Care Coordinator (RCC) on 11/05/20 at 11:07am revealed: -She was responsible for overseeing the care of the residents in the SCU. -Resident #1 was not currently receiving PT. -She had not seen the recommendation from PT	D 273	During weekly at risk RCD, RCC+ED orders are reviewed to ensure follow up w/clinical, therapy and therapy mgr. attends stand up and at risk meetings to ensure timely follow up and implementation of any therapy orders. at risk weekly - ongoing Review of orders during at risk where appropriate by RCD, RCC or designated clinical staff to therapy designee. 11/24/20 Discharge summaries will be faxed over to Primary Care physicians for review upon residents return from	

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D 273	Continued From page 10 in the hospital discharge summary for Resident #1 dated 10/14/20. -She had not sent the hospital discharge summary/paperwork to the PCP because she did not know she needed to send it. -She read over the hospital discharge summary dated 10/14/20 and requested the resident receive an acute care virtual visit with the PCP. -She thought she requested Resident #1 be seen by PT prior to 11/04/20, but the PCP wanted to see Resident #1 before ordering PT. -She completed a PT referral with the in-house PT on 11/05/20, because the resident had a fall on 11/04/20. Interview with Resident #1's Responsible Party (RP) on 11/06/20 at 12:16pm revealed: -She was at the hospital with Resident #1 from 10/12/20-10/14/20. -She remembered PT coming to the room to assess Resident #1. -She did not remember PT's recommendation for Resident #1. -The RCC informed her that Resident #1 would be assessed by the in-house PT when she returned from the hospital on 10/14/20. -No one had reached out to obtain a consent for PT services. Telephone interview with Resident #1's PCP on 11/06/20 at 12:30pm revealed: -She did not know Resident #1 was hospitalized on 10/14/20 for seizure activity. -Resident #1 became her patient on 10/20/20. -She had not received the hospital discharge summary from the facility. -She did not have access to the hospital discharge summary unless someone from the facility sent it to her. -She would expect the discharge summary to be	D 273	See pg 10 hospital by designated clinical staff w/ oversight from RCD/ RCC.	11/12/20

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D 273	Continued From page 11 sent within a week so that she could write any orders based on the hospital's recommendations. -She would have expected a follow-up visit to be scheduled once Resident #1 returned from the hospital. -She was sent a request from staff on 11/05/20 for a PT referral. -If the she had known about the PT recommendation, she would have ordered PT for the resident to be seen. -PT could have prevented Resident #1's subsequent falls and injury. Interview with the facility's contracted Physical Therapist on 11/09/20 at 12:20 revealed: -Residents who needed to be assessed by PT were discussed during weekly risk meetings. -The RCC and the Administrator attended the weekly risk meetings. -Once residents were discussed he coordinated with the PCP to obtain an order and with family to obtain consent and co-pay if necessary. -If the hospital recommended PT, the Resident Care Director (RCD), or RCC would provide him with the hospital discharge summary so that he could follow-up on recommendation. -He had not received the hospital paperwork for PT for Resident #1. -He had not assessed Resident #1 and had not obtained an order from the PCP. Interview with the Administrator on 11/12/20 at 3:15pm revealed: -She did not know Resident #1 had been hospitalized on 10/14/20 and assessed by PT. -She expected the RCC and RCD to review the hospital discharge summary and send to the physician once the resident returned to the facility. -She would expect the RCC or RCD to reach out	D 273		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 12 to the PCP to determine if the resident would be appropriate for PT and obtain an order. -The facility had an in-house PT provider that could provide services when needed. -The in-house PT would follow-up with the PCP and RP to get required information to initiate services. b. Review of hospital discharge summary dated 10/02/20 revealed Resident #1 was hospitalized with a primary diagnosis of colitis (an inflammatory reaction of the colon), the resident presented with diarrhea and abdominal pain. Review of Resident #1's vital signs revealed her weight on 10/07/20 was 134 pounds. Review of Resident #1's physician's orders revealed there was an order dated 10/20/20 to discontinue a nutritional supplement and complete daily weights until next follow-up visit, and report a weight loss of 2 pounds or more in a week to provider. Review of Resident #1's record revealed: -Resident #1's weight was as 135.2 on 10/21/20, 130.6 on 10/28/20 and 126.4 on 10/30/20. -The resident lost 5 pounds in a week and 9 pounds in 11 days. -There was no documentation the primary care provider (PCP) had been notified. Review of Resident #1's progress notes revealed: -On 10/25/20 at 10:47am, the resident refused to eat breakfast and when offered nutritional supplements, she drank one half of a cup of one and would not drink the the other nutritional supplement offered. -On 10/25/20 at 12:10pm, the resident ate 25 percent of her lunch.	D 273		

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D 273	Continued From page 13 -On 10/31/20 at 4:12pm, the resident ate less than 75% of meal with a nutritional supplement. -There was no documentation, the physician was notified about weight loss from 10/21/20-10/30/20. Interview with a medication aide (MA) on 11/09/20 at 10:50am revealed: -Resident #1 had a poor appetite. -She did not know Resident #1 had an order for daily weights dated 10/20/20. -The personal care aides (PCAs) were responsible for obtaining weights and giving them to the MA to record in the electronic Medication Administration Record (eMAR). Interview with the Resident Care Coordinator (RCC) on 11/05/20 at 11:07am revealed: -PCAs were normally responsible for obtaining resident weights, but she obtained the weights since they were to be completed daily. -She remembered faxing the weights to the PCP and did not receive new orders or a response from the PCP. -She did not know why she had not reached out to the PCP for recommendations or new orders. -She could not find a fax confirmation to verify the weights were sent. -She was responsible for communicating any changes with the PCP regarding any changes with residents in the special care unit (SCU). Interview with Resident #1's PCP on 11/06/20 at 12:30pm revealed: -She knew Resident #1 was discharged from the hospital with a diagnosis of colitis on 10/02/20. -Since she discontinued Resident #1's nutritional supplements, she ordered daily weights to determine how fast the resident was losing weight.	D 273		

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D 273	Continued From page 14 -If she would have known about the 5-pound weight loss in a week and 9 pounds in 11 days, she would have investigated other treatment options, including medications to boost appetite. -If Resident #1 continued to lose weight at a fast pace her body would be starving of nutrients and eventually, she could not survive. -She expected to be notified as ordered by facility staff. Interview with the Administrator on 11/12/20 at 3:15pm revealed: -The RCC was responsible for notifying the PCP as ordered. -She did not know Resident #1 had an order for daily weights. -She did not know Resident #1 lost 5 pounds in a week and 9 pounds in 11 days. -She expected the PCP to be notified of significant weight loss. -Changes with residents were discussed in weekly risk meetings, she did not remember discussing Resident #1. The facility failed to ensure 1 of 3 residents sampled (#1) received referral and follow-up related to physical therapy which resulted in the resident having subsequent falls including a fall with a head injury that resulted in an Emergency Room visit and not notifying the physician of a 9-pound weight loss in 11 days, putting the resident at risk for starvation of nutrients. The facility's failure was detrimental to the health, safety and well-being of Resident #1, which constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on November 30, 2020 for this violation.	D 273		

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D 273	Continued From page 15 THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 27, 2020 .	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a physician orders were implemented for 1 of 5 sampled residents (#2) for laboratory studies and home health skilled nursing orders. The findings are: 1. Review of Resident #2's current FL-2 dated 09/24/20 revealed diagnoses included asthma. a. Review of Resident #2's subsequent physician orders dated 10/15/20 revealed there was an order for baseline laboratory studies complete	D 276	RCD/RCC and or Clinical Staff designee to review and sign off on weekly orders ~~have been~~ once reviewed, implimented after RCD/RCC and Clinical Staff will Review orders received by ~~a~~ Healthcare providers RCD/RCC will both review all orders received on a weekly basis & Sign. ~~to~~ as evidence of review, to ensure timely implementation and follow up by 12/24/2020.	

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D 276	Continued From page 16 blood county (CBC), C- reactive protein (CRP), ferritin, complete metabolic panel (CMP), D-Dimer, and repeat labs in 48 hours. Review of Resident #2's laboratory tests results revealed there were labs completed for the first set of studies, but no additional labs studies for the 48-hour repeat. Interview with Resident #2 on 11/04/20 at 2:20pm revealed: -She remembered having blood work obtained in October 2020 but was unsure what the blood work was for. -She could not recall a second time blood work obtained in October 2020. -She tested positive for COVID-19 on 10/15/20 and was moved to the isolation hall on the 3rd floor. -She did not have any blood work obtained on the 3rd floor while she was in isolation. Interview with Resident #2's Primary Care Provider (PCP) on 11/05/20 at 2:11pm revealed: -There were one set of laboratory studies drawn for Resident #2 on 10/19/20. -She ordered additional laboratory studies to be obtained 48 hours after the first set. -The facility never implemented the second set of labs for Resident #2. -The PCP did not have Resident #2's results for the second set of labs ordered 48 hours after the first set. -Resident #2 tested positive for COVID-19 on 10/15/20. -The PCP wanted to compare the labs due to COVID-19 infection. -Resident #2 had a chest x-ray on 10/15/20 which showed pneumonia. -It was very important to compare the labs due to	D 276		

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D 276	Continued From page 17 Resident #2 testing positive for COVID-19, pneumonia, and a history of asthma. Interview with a medication aide (MA) on 11/05/20 at 10:35am revealed: -The MAs did not process laboratory orders. -The Director of Resident Care (DRC) handled all laboratory orders. Interview with the DRC on 11/05/20 at 11:16am revealed: -When the PCP told her what laboratory testing they wanted to order, and she completed a requisition form for the laboratory test. -The phlebotomist for the laboratory company came to the facility to complete laboratory blood draws. -When Resident #2's PCP wrote orders for laboratory tests to be drawn and repeat in 48 hours, she thought she had told the phlebotomist the order. -It was responsibility for ensuring laboratory tests were completed for residents at the facility. Interview with the Administrator on 11/12/20 at 3:42pm revealed: -She expected the DRC to have residents' laboratory tests drawn and completed as ordered. -She did not know Resident #2 had laboratory studies ordered for October 2020. -The DRC was responsible for ensuring laboratory tests were completed for the residents. b. Review of Resident #2's subsequent physician orders revealed there was an order dated 10/15/20 for Home Health (HH) for skilled nursing for close monitoring of patients condition. Interview with Resident #2 on 11/04/20 at 2:20pm revealed:	D 276		

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D 276	Continued From page 18 -She had never seen a HH nurse or had an evaluation for a HH skilled nursing visits since her admission on 09/28/20. -She tested positive for COVID-19 on 10/15/20 and was moved to the isolation hall on the 3rd floor. -She did not have a HH nurse monitor her while on the 3rd floor in isolation. Interview with Resident #2's PCP on 11/05/20 at 2:11pm revealed: -She ordered HH skilled nursing for Resident #2 due to Resident #2 testing positive for COVID-19, pneumonia and having a history of asthma. -She expected her orders to be followed and implemented. -The HH nurse was to oversee Resident #2's care while she was in isolation for COVID-19 on the third floor. -The HH nurse would report any changes in condition to her. -The PCP was not aware the order was never implemented for HH services. Interview with the DRC on 11/05/20 at 11:16am revealed: -She was aware Resident #2 tested positive for COVID-19 on 10/15/20. -She knew Resident #2 was diagnosed with pneumonia on 10/15/20. -She did not know Resident #2 had an order for HH skilled nursing to monitor due COVID-19 and pneumonia. -She was responsible for reviewing orders and contacting the HH agency for new referrals. -She never contacted the HH agency for Resident #2's order for HH services on 10/15/20. Interview with the Administrator on 11/12/20 at 3:42pm revealed:	D 276		

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D 276	Continued From page 19 -She knew Resident #2 tested positive for COVID-19 on 10/15/20 and had a chest x-ray on 10/15/20 which showed pneumonia. -She was not aware Resident #2's order was for HH skilled nursing. -She relied on the DRC to complete orders as the PCP had written them. -She expected the DRC to implement the orders on 10/15/20 for Resident #2 to have HH skilled nursing.	D 276	all Charts were reviewed by RCD + RCC to make sure all orders had been reviewed and followed from PCP recommendations. a review of PT/OT/ST orders were also reviewed. 12/5/20	
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents and to reduce the risk of transmission and infection during the global coronavirus (COVID-19) pandemic as related to rapidly taking action to test staff and all residents and retesting of staff and residents that were negative for COVID-19 weekly after an outbreak; a staff only being tested once from August to October 2020 (Staff G); residents admitted during the COVID-19 outbreak from 08/06/20 through	D 338	10 NCAC 13F.0909 Resident Rights ED, RCD + RCC based on advisement from Contagious disease nurse were providing end of life compassionate care during outbreak. Going forward we will allow compassionate care visits inside as required based on State guidelines. a Schedule is posted at the front desk for residents on compassionate care. a designated	

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D 338	Continued From page 20 10/26/20 with recommendations from the LHD to stop admissions; and accommodating compassionate care visits for a resident with significant weight loss and decline (Resident #1). The findings are: Review of the CDC guidelines to prevent the spread of COVID-19 in Assisted Living facilities (ALFs) revealed: -Identify a point of contact at the LHD to facilitate prompt notification as follows: -Immediately notify the LHD about any of the following: -If COVID-19 was suspected or confirmed among residents or facility personnel. -If a resident developed severe respiratory infection resulting in hospitalization. -If 3 or more residents or facility personnel developed new-onset respiratory symptoms within 72 hours of each other. -Prompt notification of the LHD about residents and personnel with suspected or confirmed COVID-19 was critical. The LHD could help ensure all recommended infection prevention and control measures were in place. Often, when a new-onset infection was identified, there were others in the facility who were also infected but who did not yet have symptoms. Rapid action to identify, isolate, and test others who might be infected was critical to prevent further spread. Review of North Carolina Department of Health and Human Services (NC DHHS) "What to Expect: Response to New COVID-19 Cases or Outbreaks in Long Term Care Settings" dated 09/04/20 revealed: -Follow NC DHHS and CDC guidance. -The LHD would provide guidance on patient placement, cohorting of residents and staff, and environmental cleaning.	D 338	10 NCAC 13F .0909 Resident Rights cont. supervised visit is allowed as needed based on individual needs of the resident. Assistance with visits are provided by clinical team CNAs, Med Techs, SIC or clinical or social assistant. 11/12/20	

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D 338	Continued From page 21 -Check CDC guidance for the most up-to-date infection prevention recommendations for long-term care settings. -Any testing of facility residents or staff will be conducted in consultation with your LHD. Review of the LHD's COVID-19 testing resources for long term care facilities with identified cases of COVID-19 dated September 2020 revealed: -Notify LHD of any suspected or confirmed cases of COVID-19. -Perform viral testing of all previously negative residents and staff if there are one or more cases of COVID-19 identified. -Continue repeat viral testing of all previously negative residents and staff as follows: -Immediately perform viral testing of any resident or staff who subsequently developed signs or symptoms consistent with COVID-19. -Perform repeat testing for all asymptomatic previously negative residents and staff approximately every 3-7 days for a period of at least 14 days since the most recent positive result. Review of the Centers for Disease Control (CDC) guidelines for Repeat Testing in Coordination with the Health Department for coronavirus in long-term care (LTC) facilities revealed: -After initially performing viral testing of all residents in response to an outbreak, CDC recommends repeat testing to ensure there are no new infections among residents and healthcare personnel (HCP) and that transmission has been terminated as described below. -Repeat testing should be coordinated with the local, territorial, or state health department. -Continue repeat viral testing of all previously negative residents, generally every 3 days to 7	D 338	10A NCAC 13F .0909 Resident Rights Cont. Testing is provided for staff and mandatory every 3 to 7 days. A spreadsheet was cont...	

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D 338	Continued From page 22 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. -This follow-up viral testing can assist in the clinical management of infected residents and in the implementation of infection control interventions to prevent SARS-CoV-2 transmission. -If viral test capacity is limited, CDC suggests directing repeat rounds of testing to residents who leave and return to the facility (e.g., for outpatient dialysis) or have known exposure to a case (e.g., roommates of cases or those cared for by a HCP with confirmed SARS-CoV-2 infection). -For large facilities with limited viral test capacity, testing only residents on affected units could be considered, especially if facility-wide repeat viral testing demonstrates no transmission beyond a limited number of units. Review of the facility's census dated 11/04/20 revealed there were 27 residents in the Assisted Living and 23 residents in the Alzheimers special care unit (SCU). Review of the facility's census admissions from 8/14/20 until 10/26/20 revealed: -There were 12 new admissions to the facility. -In August 2020 there were residents admitted on 08/14/20, 08/24/20, and on 08/25/20. -In September 2020 there were residents admitted on 09/17/20 and 09/28/20. -In October 2020 there were residents admitted on 10/01/20, 10/12/20, 10/22/20 and on 10/26/20. Telephone interview with the communicable disease (CD) nurse for the LHD on 11/04/20 at 8:40am revealed:	D 338	10A NCAC .0909 Resident Rights cont. developed by RCD + BOM to make sure staff scheduled have had proper timely tests. All staff are required to test.	11/12/20

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D 338	Continued From page 23 -The facility reached out to her on 08/06/20 with the first outbreak of COVID-19 identifying 1 staff and 1 resident tested positive for COVID-19. -On 09/17/20 the facility reached out to the LHD nurse identifying 2 staff testing positive for COVID-19 on 09/15/20. -There were 8 more staff and 5 residents testing positive for COVID-19 by 10/14/20. Review of the electronic mail dated 09/18/20 from the CD Nurse from the LHD Communicable Disease Division to the Administrator revealed: -The LHD sent web links to the CDC and NC DHHS guidance on COVID-19 control measures that were to be implemented immediately. -A blank COVID-19 Monitoring log form was attached to the email. -There were instructions for the Administrator to complete the log and notify the LHD of any new staff or resident cases of COVID-19. 1.a. Review of the facility's COVID-19 Monitoring Log for employees revealed 10 staff tested positive for COVID-19 from 9/15/20 to 10/14/20. Review of the staff's COVID-19 test results from the weeks of 09/14/20 and 9/21/20 revealed: -Two staff tested positive for COVID-19 on 09/15/20 and one staff on 09/26/20. -There were 30 of 67 staff who were not initially tested in that 14-day time frame. Review of the staff's COVID-19 test results from the week of 09/28/20 revealed: -Five staff tested positive for COVID-19. -There were 37 of 66 staff who tested negative that were not retested. Review of the staff's COVID-19 test results from the week of 10/05/20 revealed 22 of 60 staff who	D 338		

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D 338	Continued From page 24 tested negative were not retested. Review of the staff's COVID-19 test results from the week of 10/12/20 revealed: -Two staff tested positive for COVID-19 on 10/12/20 and 10/13/20. -There were 22 of 62 staff who tested negative that were not retested. Review of the staff's COVID-19 test results from the week of 10/19/20 revealed 31 of 59 staff who tested negative were not retested. Review of the staff's COVID-19 test results from the week of 10/26/20 revealed 26 of 61 negative staff were not retested. Review of Staff G's personnel file revealed: -Staff G was hired on 10/07/19 as a personal care aide (PCA). -Her duties included assisting residents bathing, dressing, grooming and transportation. Review of the facility work scheduled revealed: -Staff G worked in the facility on 3rd shift 30 to 40 hours weekly. -Staff G worked in the special care unit (SCU) and the assisted living side. -Staff G worked on 11/04/20 on 3rd shift. Telephone interview with Staff G on 11/10/20 at 6:03am revealed: -She worked in the facility as a PCA on 3rd shift. -She worked both on the SCU and assisted living side. -She was part time but worked about 30-35 hours a week. -She was tested for COVID-19 in August 2020, but she could not remember the date. -She was never retested after the initial test in	D 338		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 25 August 2020. -She tested negative for COVID-19 in August 2020. -She was aware she needed to be tested again for COVID-19. -She was not tested because there was no one on 3rd shift to perform the COVID-19 test. -The facility offered COVID-19 testing on 1st and 2nd shift only, and she could not stay over or come in early. -The Director of Resident Care (DRC), the Resident Care Coordinator (RCC), and the Administrator never told her she could not work if she did not have the COVID-19 test. Review of the staff's COVID-19 test results revealed: -Staff G had tested negative for COVID-19 on 08/04/20. -There were no other tests performed until November 2020. Interview with the DRC on 11/05/20 at 10:47am revealed: -She did not know Staff G was not tested following the guidelines recommended by the LHD. -She had overlooked Staff G not being tested for COVID-19. -She thought all staff were tested for COVID-19. -She was responsible for completing the staff schedule. Interview with the Administrator on 11/05/20 at 4:10pm revealed: -She was not aware Staff G was not tested for COVID-19 during the outbreak. -She thought all staff and residents were tested for COVID-19 following the guidelines from the LHD.	D 338		

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	HAL060158	A. BUILDING: _____ B. WING _____	C 11/12/2020

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D 338	Continued From page 26 -She was responsible for the COVID-19 Monitoring Log, but that only included positive test results. -Sometimes it was hard to get as needed (PRN) staff tested because they were employed at other facilities and only worked in her facility part time. -The DRC and the RCC completed the staff schedules. -The DRC and the RCC were responsible for testing all staff for COVID-19. b. Review of the facility's COVID-19 Monitoring Log for residents revealed 5 residents tested positive for COVID-19 from 10/02/20 to 10/14/20. Review of the residents' COVID-19 test results from the week of 09/14/20 revealed 19 of 35 residents were not initially tested. Review of the residents' COVID-19 test results from the week of 09/21/20 revealed 19 of 39 residents were not tested. Review of the residents' COVID-19 test results from the week of 09/28/20 revealed: -There was one resident who tested positive on 10/02/20. -There were 21 of 41 residents who were not retested. Review of the residents' COVID-19 test results from the week of 10/05/20 revealed -There was two residents who tested positive on 10/05/20. -There were 4 of 39 residents who were not retested. Review of the residents' COVID-19 test results from the week of 10/12/20 revealed -There was one resident who tested positive on	D 338		

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D 338	Continued From page 27 10/13/20 and one on 10/14/20. -There was 1 of 40 residents who tested negative who was not retested. Review of the residents' COVID-19 test results from the week of 10/19/20 revealed 5 of 40 residents who tested negative were not retested. Review of the residents' COVID-19 test results from the week of 10/26/20 revealed 21 of 41 residents who tested negative were not retested. Review of emails and notes from the CD nurse to the Administrator revealed: -On 09/18/20, the Administrator reported that full facility testing would be 90% completed by 9/18/20 and the remainder would be completed by 09/21/20. -On 09/23/20, all COVID-19 tests for residents and staff had been completed and had come back negative and the facility would be starting the second round of testing. -On 09/28/20 the Administrator reported the facility was currently testing weekly. -On 09/29/20 the Administrator reported all tests were negative, and weekly testing would be continued. -On 10/04/20 the CD nurse received 3 voicemails reporting 5 staff who had tested positive. -On 10/05/20 the Administrator reported 5 staff and 1 resident who had tested positive. -On 10/07/20 the Administrator reported 2 residents who had tested positive, and had moved all positive residents to the third floor COVID-19 unit. -On 10/09/20 the Administrator reported they did not have N95 masks, so the CD nurse gave her ordering information for them. -On 10/15/20 the Administrator reported 1 staff and 2 residents who had tested positive.	D 338		

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D 338	Continued From page 28 -On 10/22/20, the Administrator reported the last round of testing was negative and the facility would be retesting this week. -On 10/26/20, the Administrator reported testing from the past week was negative and the facility would be moving to biweekly testing of staff. -On 10/26/20, the Administrator stated "They have tested negative two weeks straight." -On 10/28/20, the Administrator notified the CD nurse that the facility would be testing staff and residents on 10/28/20 and 10/29/20. -On 11/04/20, the Administrator reported no positive tests from the previous week's testing and no one with symptoms. -On 11/04/20, the Administrator wanted to know if they could go to biweekly testing, and was told not yet, due to the county's increased COVID-19 positivity rate. Interview with a medication aide (MA) on 11/04/20 at 10:00am revealed: -The facility had tested all staff and residents on 10/29/20 for COVID-19. -All tests came back negative. -The DRC was responsible for performing the testing. Interview with the DRC on 11/04/20 at 10:53am revealed: -They have no positive COVID-19 cases currently. -They had two residents on isolation for 14 days because of a recent hospital stay. -The facility started testing for COVID-19 in August 2020. -A lab company provided test kits and they could get results in 24-48 hours. Interview with the Administrator on 11/04/20 at 1:35pm revealed:	D 338		

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D 338	Continued From page 29 -The last resident tested positive for COVID-19 on 10/14/20 -She was initially instructed by the LHD to perform weekly COVID-19 testing for residents and staff for 14 days, and then if there were no positive results they could begin biweekly testing of staff only, and then monthly testing. -They had recently completed weekly testing on 10/27/20 and 10/29/30 of all residents and staff who tested negative. -The LHD had instructed them to not test residents or staff for 90 days who had tested positive. Interview with the Administrator on 11/09/20 at 11:05am revealed: -The current 28 day outbreak status which started with the most recent positive case on 10/14/20 was supposed to end on 11/11/20. -She was not aware all the negatives (staff and residents) were not being retested every week, and said "[name of DRC] should have come to me." Interview with the DRC on 11/09/20 at 11:05am revealed: -She was responsible for COVID-19 testing of all staff and residents. -She did not have a spreadsheet of COVID-19 testing until last week. -The Administrator had a COVID-19 Monitoring log for residents and staff which she sent to the LHD, which only included the positive cases. -The "ball was dropped" due to not testing the negatives weekly within the 3-7 day timeframe. Interview with the DRC on 11/12/20 at 10:45am revealed: -There were several missed COVID-19 tests for third shift staff because staff did not want to come	D 338		

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D 338	Continued From page 30 in to be tested. -There were 2 staff that had not been tested in the past because one staff worked 3rd shift as needed, and the other staff just worked weekends. -She planned to train the supervisors on third shift to perform the testing. -Weekly testing was not done for all residents and staff because the system she had in place did not work. -She was testing some people twice a week and then missed them the next week. -She did not keep a spreadsheet in the past. -She would be using the team member list and the census to keep up with testing. -She was responsible for the COVID-19 testing for residents and staff. -She reported directly to the Administrator. Review of the facility's Coronavirus Disease (COVID-19) Prevention and Control policy revealed the current CDC guidelines would be followed for infection prevention and control of residents diagnosed with COVID-19. Review of the facility's Quarantine Policy Statement revealed the facility would protect the health and well-being of residents and staff during infectious disease outbreaks. 2. Telephone interview with the communicable disease nurse for the local Health Department on 11/04/20 at 8:40am revealed: -The facility reached out to her on 08/06/20 with the first outbreak of COVID-19 identifying 1 staff and 1 resident tested positive for COVID-19. -The LHD and the LHD Medical Director recommended to stop admissions until COVID-19 outbreak was over. -The Administrator requested 2 new residents be	D 338		

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D 338	Continued From page 31 admitted because they were in the process of moving into the facility at that time. -The LHD nurse and the LHD Medical Director agreed to the 2 new admissions only, but the 2 new admissions were to be quarantined for 14 days due to the COVID-19 outbreak in the facility. -On 09/17/20 the Administrator reached out to the LHD nurse identifying 5 residents and 10 staff who tested positive for COVID-19. -On 09/17/20 the LHD nurse and the LHD Medical Director again recommended stopping admissions due to COVID-19 outbreak. -A family member contacted the LHD nurse on 10/20/20 because of COVID-19 in the facility. -The family member looked on the internet COVID-19 dashboard and identified COVID-19 in the facility. -The family member had admitted her family member to the facility 10/05/20 and was not informed of COVID-19 outbreak in the facility. -The facility had 2 residents test positive for COVID-19 in the facility on 10/15/20. -The LHD nurse again contacted the Administrator on 10/20/20 and informed her of the LHD nurse and the LHD Medical Director recommendation for no new admissions to the facility until all residents and staff were cleared of COVID-19. -The LHD nurse also informed the Administrator on 10/20/20 she must disclose to the families and the residents about COVID-19 in the building. a. Review of Resident #2's current FL-2 dated 09/24/20 revealed diagnoses included asthma. Review of Resident #2's Resident Register revealed an admission date of 09/28/20. Interview with Resident #2 on 11/04/20 at 2:20pm revealed:	D 338		

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D 338	Continued From page 32 -She was admitted on 09/28/20. -She was tested for COVID-19 prior to her admission and tested negative. -She was tested for COVID-19 on 10/02/20 and on 10/05/20, both were negative. -She was tested on 10/13/20 for COVID-19 and the results came back on 10/15/20 she was positive. -She had not left her room or went outside to any appointment or physician visit since her admission on 09/28/20. -She was not made aware of COVID-19 outbreak in the facility on her admission. Telephone interview with Resident #2's Power of Attorney (POA) on 11/06/20 at 8:35am revealed: -Resident #2 was admitted to the facility on 09/28/20. -She was screened at the front desk for COVID-19 which included completing a questionnaire and having her temperature taken. -She was never told the facility had a COVID-19 outbreak. -She would like to have known the facility had an outbreak of COVID-19 prior to admitting her family member to the facility. Refer to interview with a medication aide (MA) on 11/05/20 at 11:45am. Refer to interview with the Administrator on 11/05/20 at 4:10pm. Refer to interview with the Director of Resident Care on 09/11/20 at 4:53pm. Refer to interview with the Marketing representative on 11/05/20 at 4:00pm. b. Review of Resident #7's current FL2 dated	D 338		

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D 338	Continued From page 33 10/01/20 revealed diagnoses included chronic lower back pain, compression fractures and mild cognitive impairment. Review of Resident #7's Resident Register revealed there was no admission date noted. Review of Resident #7's care notes revealed documentation Resident #7 moved in on 10/06/20. Telephone interview with Resident #7's Power of Attorney (POA) revealed: -Resident #7 was admitted to the facility on 10/05/20. -He toured the facility with the marketing representative. -He was not informed of a COVID-19 outbreak in the facility nor of the isolation/ quarantine requirements for Resident #7. -Staff had told him Resident #7 was quarantined to his room and could not leave the room. -Another family member contacted the LHD with concerns of the COVID-19 outbreak in the facility during the time Resident #7 was admitted. -He moved Resident #7 out of the facility due to the facility not disclosing facts about COVID-19 and the quarantine for Resident #7. Review of the care note dated 10/29/20 revealed Resident #7 was discharged from the facility. Refer to interview with a medication aide (MA) on 11/05/20 at 11:45am. Refer to interview with the Administrator on 11/05/20 at 4:10pm. Refer to interview with the Director of Resident Care on 09/11/20 at 4:53pm.	D 338		

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D 338	Continued From page 34 Refer to interview with the Marketing representative on 11/05/20 at 4:00pm. c. Review of Resident #11's current FL2 dated 10/20/20 revealed diagnoses included hypothyroidism, fall risk, left pelvic fracture and chronic kidney disease. Review of Resident #11's Resident Register revealed an admission date of 10/22/20. Interview with Resident #11 on 11/09/20 at 11:05am revealed: -She was admitted to the facility last month in October 2020. -She had been in quarantine since her admission. -She was never told by the facility there was an outbreak of COVID-19 in the facility prior to her admission. -She was unsure if her family was informed about the outbreak prior to her admission. Refer to interview with a medication aide (MA) on 11/05/20 at 11:45am. Refer to interview with the Administrator on 11/05/20 at 4:10pm. Refer to interview with the Director of Resident Care on 09/11/20 at 4:53pm. Refer to interview with the Marketing representative on 11/05/20 at 4:00pm. d. Review of Resident #12's current FL2 dated revealed diagnoses included dementia and peripheral venous insufficiency. Review of Resident #12's Resident Register	D 338		

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D 338	Continued From page 35 revealed an admission date of 09/28/20. Telephone interview with Resident #12's Power of Attorney (POA) on 11/06/20 at 8:35am revealed: -Resident #12 was admitted to the facility on 09/28/20. -She toured the facility on 09/09/20 prior to admitting Resident #12 to the facility. -She was never told the facility had a COVID-19 outbreak. -She would like to have known the facility had an outbreak of COVID-19 prior to admitting her family member to the facility. Interview with Resident #12 on 11/04/20 at 2:20pm revealed she was not made aware of the COVID-19 outbreak in the building until Resident #2 tested positive for COVID-19 on 10/15/20. Refer to interview with a medication aide (MA) on 11/05/20 at 11:45am. Refer to interview with the Administrator on 11/05/20 at 4:10pm. Refer to interview with the Director of Resident Care on 09/11/20 at 4:53pm. Refer to interview with the Marketing representative on 11/05/20 at 4:00pm. e. Review of Resident #10's current FL2 dated 09/24/20 revealed diagnoses included vascular dementia, chronic kidney disease and anxiety. Review of Resident #10's Resident Register revealed there was no admission date noted. Review of Resident #10's care note revealed a note Resident #10 moved in on 10/12/20.	D 338		

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D 338	Continued From page 36 Telephone interview with Resident #10's Power of Attorney (POA) revealed: -Resident #10 was admitted to the facility on 10/12/20. -She toured the facility in August 2020 and was told there was 1 case of COVID-19 in the building. -The Administrator sent her emails weekly but never mentioned an outbreak of COVID-19 in the facility after August 2020. -"I would like to have known if the facility had more COVID-19 in the building." Based on observations and interviews, it was determined Resident #10 was not interviewable. Refer to interview with a medication aide (MA) on 11/05/20 at 11:45am. Refer to interview with the Administrator on 11/05/20 at 4:10pm. Refer to interview with the Director of Resident Care on 09/11/20 at 4:53pm. Refer to interview with the Marketing representative on 11/05/20 at 4:00pm. f. Review of Resident #13's current FL2 dated 10/23/20 revealed: -Diagnoses included Dementia. -An order for an admission to the Special Care Unit (SCU). Review of Resident #13's Resident Register revealed an admission date of 10/25/20. Telephone interview with Resident #13's Power of Attorney (POA) on 11/10/20 at 9:15am revealed:	D 338		

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D 338	Continued From page 37 -Resident #13 was admitted to the SCU on 10/25/20. -The Administrator emailed her updated weekly but had never mentioned the outbreak of COVID-19. -She was not aware of the outbreak of COVID-19 in the facility prior to admission on Resident #13 to the SCU. -She would like to have known if the facility had any residents or staff with COVID-19. Based on observations and interviews, it was determined Resident #13 was not interviewable. Refer to interview with a medication aide (MA) on 11/05/20 at 11:45am. Refer to interview with the Administrator on 11/05/20 at 4:10pm. Refer to interview with the Director of Resident Care on 09/11/20 at 4:53pm. Refer to interview with the Marketing representative on 11/05/20 at 4:00pm. g. Review of Resident #8's current FL2 dated 10/22/20 revealed diagnoses included dementia, hypertension, altered mental status. Review of Resident #8's Resident Register revealed there was no admission date noted. Review of the facility census report which included the admission dates revealed Resident #8 was admitted on 10/01/20. Telephone interview with Resident #8's POA on 11/10/20 at 10:47am revealed: -Resident #8 was admitted to the facility on	D 338		

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D 338	Continued From page 38 10/05/20. -She toured the facility about 6 weeks prior to Resident #8's admissions to the facility. -The facility staff asked her to wear a gown, mask and gloves when she toured. -The staff never mentioned an outbreak of COVID-19 in the facility during the tour; she thought that it was protocol for all visitors to wear protective personal equipment (PPE). -When Resident #8 was admitted she was not made aware of an outbreak of COVID-19. -She would like to have known if the facility had an outbreak COVID-19 when she toured and when she admitted her family member to the facility. Attempted interview with Resident #8 on 11/09/20 at 11:49am was unsuccessful. Refer to interview with a medication aide (MA) on 11/05/20 at 11:45am. Refer to interview with the Administrator on 11/05/20 at 4:10pm. Refer to interview with the Director of Resident Care on 09/11/20 at 4:53pm. Refer to interview with the Marketing representative on 11/05/20 at 4:00pm. h. Review of Resident #9's current FL2 dated 09/03/20 revealed diagnoses included hypertension and osteoarthritis. Review of Resident #9's Resident Register revealed there was no admission date noted. Review of the facility census report which included the admission dates revealed Resident	D 338		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 39 #9 was admitted on 10/01/20. Telephone interview with Resident #9's POA on 11/10/20 at 10:47am revealed: -Resident #9 was admitted to the facility on 10/01/20. -She toured the facility about 6 weeks prior to Resident #9's admission and was asked her to wear a gown, mask and gloves when she toured. -The staff never mentioned an outbreak of COVID-19 in the facility during the tour; she thought that it was protocol for all visitors to wear protective personal equipment (PPE). -When Resident #9 was admitted she was not made aware of an outbreak of COVID-19 in the facility. -She would like to have known if the facility had an outbreak of COVID-19 when she toured and also when she admitted her family member to the facility. Refer to interview with a medication aide (MA) on 11/05/20 at 11:45am revealed: Refer to interview with the Administrator on 11/05/20 at 4:10pm revealed: Refer to interview with the Director of Resident Care on 09/11/20 at 4:53pm. Refer to interview with the Marketing representative on 11/05/20 at 4:00pm. _____ Interview with a medication aide (MA) on 11/05/20 at 11:45am revealed: -Residents were moved to the 3rd floor if they tested positive for COVID-19. -Families toured the facility during the COVID-19 outbreak.	D 338		

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D 338	Continued From page 40 Interview with the Administrator on 11/05/20 at 4:10pm revealed: -She contacted the LHD for guidance in August 2020 and continued to be in touch with the LHD during the COVID-19 outbreak in the facility. -She admitted several residents to the facility because the corporate office gave her the approval to admit. -She could not recall the LHD nurse and the LHD Medical Director informing her to stop admissions due to the COVID-19 outbreak. -She had not disclosed to the families of the new admission or the residents the facility had an outbreak of COVID-19. -The marketing representatives were responsible for informing the family prior to admission. -She could not recall telling the families the residents would be quarantined for 14 days prior to admission in the facility. Interview with the Director of Resident Care on 09/11/20 at 4:53pm revealed: -The marketers were conducting tours in the facility during the COVID-19 outbreak. -She was introduced to the families during the tours. -She had not mentioned COVID-19 to the families, because that was the marketer's responsibility. -She was unsure if the families knew about the outbreak of COVID-19 in the facility prior to admission of the residents. Interview with the Marketing representative on 11/05/20 at 4:00pm revealed: -She was responsible for conducting tours and providing information to individuals and their families who were interested in their community. -She did not speak to or address any clinical	D 338		

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D 338	Continued From page 41 questions the individuals or families would pose. -She referred all clinical questions to the nursing staff. -She did not inform those she toured in the community that the facility had an outbreak of COVID-19. -She did not feel that was her responsibility, or that she was qualified to answer any questions they may have. -That would be the responsibility of the clinical staff. 4. Review of the NC Department of Health and Human Services (NC DHHS) Guidance on Visitation, Communal Dining and Indoor Activities for Larger Residential Settings dated 09/28/20 revealed: -There was guidance provided for conducting compassionate care visits. -While end-of-life situations have been used as examples of compassionate care situations, the term "compassionate care situations" does not exclusively refer to end-of-life situations. -Examples of other types of compassionate care situations included a resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration. Review of Resident #1's current FL2 dated 10/14/20 revealed diagnoses included seizure activity. Interview with Resident #1's Responsible Party (RP) on 11/03/20 at 2:55pm revealed: -Resident #1 had been hospitalized twice in October 2020, once for colitis (an inflammatory reaction of the colon) and then she was evaluated for seizure activity. -The resident had lost about 30 pounds since	D 338		

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D 338	Continued From page 42 being admitted in December 2019. -While Resident #1 was in hospital, she was able to get her to eat meals. -Staff at the facility told her the resident was "too picky" and would not eat. -She was very concerned with the resident's weight and poor appetite. -There was not much she could do to assist as no visitors were allowed in the facility. -She heard about families coordinating compassionate care visits and asked the Resident Care Coordinator (RCC) and the Administrator about completing visits with the resident "at the beginning of October". -She was told by the RCC and Administrator that compassionate care visits were for end of life situations and the resident would not qualify. -She spoke with the regional Ombudsman on 10/21/20, who informed her that the resident would qualify for compassionate care visits due to recent hospitalization and weight loss. Review of Resident #1's documented weight on 10/07/20 was 134 pounds. Interview with the RCC on 1/09/20 at 4:15pm revealed: -She heard Resident #1's RP was going to be able to complete compassionate care visits; she set up dates and times and then she was told by the Administrator on 10/29/20 that the visits were not approved. -She notified the RP via email on 10/29/20 that the local health department's (LHD) communicable disease nurse called and stated that no visitors were allowed. -She had not reviewed the state's guidance regarding compassionate care visits, therefore she did not know who qualified for visits. -She never spoke with the LHD regarding	D 338		

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D 338	Continued From page 43 compassionate care visits. -She never spoke with the RP regarding the compassionate care eligibility; she only discussed scheduling per the instructions of the Administrator. Interview with the Regional Ombudsman on 11/09/20 at 3:58pm revealed: -She spoke to Resident #1's RP on 10/21/20 regarding the need for compassionate care visits. -She reached out to the Administrator on 10/23/20 and left a message, she did not get a response, so she called back on 10/26/20. -She spoke with the Administrator on 10/26/20 and explained qualifications and the purpose of compassionate care visits. -The Administrator informed that she had the compassionate care visits scheduled with the RP when the LHD told her that the visits were for end-of-life situations. -She explained the memorandum and guidance from the state and thought the Administrator understood the guidance. Interview with the Nurse at the LHD on 11/04/20 at 8:40am revealed: -The LHD nurse and the LHD Medical Director recommendation was to not have compassionate care unless it was a medical crisis or emergency. -The Administrator reached out to her regarding compassionate care visits due to a resident's family wanting to get the resident settled after a hospital stay. -The Administrator had another family requesting compassionate care visits due to a resident not eating much, but the Administrator had no medical concerns with the residents' health. -The Administrator was informed by the local Ombudsman a resident's family was complaining about not seeing her family in the facility for	D 338		

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D 338	Continued From page 44 compassionate care visits. -The LHD nurse explained the compassionate care document to the Administrator and emailed her a copy. -The compassionate care visit would be for a medical emergency or end of life care and with the COVID-19 outbreak in the facility the LHD could not recommend visitations. Interview with the Administrator on 11/09/20 at 11:30am revealed: -Resident #1's family member requested a compassionate care visit on 10/27/20. -The nurse with the LHD informed her that due to the COVID-19 outbreak, visitors were not allowed unless it was end-of-life as it related to compassionate care. -The Regional Ombudsman told her that Resident #1 would qualify for compassionate care visits. -She did not know Resident #1 had significant weight loss, appetite decline, mild dehydration, or recent hospitalizations. -She should have gone to the RCC or Director of Resident Care (DRC) to get an update on Resident #1's health and provide that information to the LHD. The facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), local health department (LHD), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to the residents during the global coronavirus (COVID-19) pandemic for reducing the risk of transmission and infection of COVID-19 related to not testing all residents and staff at the onset of an outbreak, not retesting the residents and staff that tested negative for	D 338		

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D 338	Continued From page 45 COVID-19 weekly after an outbreak; residents admitted to the facility during the COVID-19 outbreak with recommendations from the LHD nurse and the LHD Medical Director to stop admissions resulting in one resident contracting COVID-19 after being admitted to the facility during the COVID-19 outbreak and failed to accommodate compassionate care visits for Resident #1 who had significant weight loss and recent hospitalizations. The lack of testing in accordance with the guidance led to the inability to determine who may have been asymptomatic and this increased opportunity for disease transmission. These failures resulted in serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 11/09/20. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 12, 2020.	D 338	See previous pages for testing follow up.	
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by:	D 358	10A NCAC 13F .1004(a) Medications a cart audit review of all carts was completed 11/13/20 a weekly as of a review by VP Clinical 12/5/20 was completed after internal audit RECEIVED 12/13/20 external audit 12/14/20 Cart audits will be audited on	

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D 358	Continued From page 46 TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered for 1 of 4 residents (#14) observed during the medication pass, including an error with a medication used to treat seizures (Resident #14); and for 2 of 5 sampled residents (#4 and #1) for record reviews including medications used to treat behaviors and dementia, a medication used to treat fluid build up, a medication used to treat low blood levels of a mineral (#4); and a medication used to treat diarrhea (#1). The findings are: 1. The medication error rate was 4% as evidenced by the observation of 1 error out of 25 opportunities during the 7:30 am-9:00am medication pass on 11/09/20. Review of Resident #14's current FL-2 dated 09/29/20 revealed: -Diagnoses included dementia, aggression and a history of seizures. -The recommended level of care was the special care unit (SCU). -There was an order for Keppra 500mg, used to treat seizure disorders, two tablets (1000mg) twice a day. Observation of the medication pass on 11/09/20 at 8:45am revealed: -The medication aide (MA) removed Resident #14's blister pack from the medication cart. -The label on the blister pack read: Levetiracetam (Keppra) 500mg tablet, take 2 tablets by mouth daily. -There was a bright yellow sticker on the label	D 358	10A NCAC 13F .1004(a) medications 2nd + 3rd shift by The clinical team— RCD, RCC, SIC +/or MT weekly for 3 months then biweekly or more often as necessary 12/5/20 a 15 hour med tech training was required and was taught by Guardian Pharmacy and audited by ED, RCD + RCC. 12/1/20 12/2/20 This was required for all MT/SIC + MT. Additionally, med techs were educated on how to follow alert labels on medication cards and told to immediately notify RCD, RCC or Clinical designee 12/1/20 regarding alert. 12/2/20	

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D 358	Continued From page 47 under the directions "DO NOT CRUSH". -The MA removed 2 tablets of Keppra from the blister pack, placed them in a plastic sleeve and crushed the tablets. -She poured the powdered tablets from the plastic sleeve into a 5 ounce cup containing applesauce. -She proceeded to offer the applesauce with medication to Resident #14. -She was interrupted by the surveyor and did not administer Keppra 500mg in applesauce to the resident. Review of Resident #14's November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Keppra 500mg, 2 tablets (1000mg) twice a day, to be administered at 9:00am and 7:00pm. -There was documentation Keppra 1000mg was administered from 11/01/20 through 11/09/20 at 7:00am. -There was documentation Keppra 1000mg was administered from 11/01/20 through 11/08/20 at 7:00pm. Interview with the MA on 11/09/20 at 8:52am revealed: -She knew there was a "Do Not Crush" label on Resident #14's Keppra medication blister pack from the pharmacy. -Resident #14 could be non compliant with his medications due to his cognitive and behavioral diagnoses. -She always crushed his medications and put them in applesauce. -It was the only way she could successfully administer Resident #14's medications. -She had not reported to the Resident Care Coordinator (RCC) or the Director of Resident	D 358		

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D 358	Continued From page 48 Care (DRC) that Resident #14 would not take the two tablets of Keppra medication unless it was crushed in applesauce. -She had not contacted the pharmacy regarding crushing the Keppra tablets or receiving the medication in another form. -She had not contacted the primary care provider (PCP) to inform her Resident #14 would not take his medication unless crushed and placed in applesauce. Interview with a second MA on 11/09/20 at 3:20pm revealed: -She administered medications to the residents in the SCU and the Assisted Living Community. -She had seen Do Not Crush labels on some of the blister packs of medication for the residents. -If a resident in the SCU would only take their medication crushed in applesauce, she would crush the medication, even if it had a Do Not Crush label on the blister pack. -"If it's the only way I could get the resident to take his medications I would crush them." Interview with a pharmacist at the facility's contracted pharmacy on 11/10/20 at 3:18pm revealed: -Resident #14 had a current order for Keppra 500mg, 2 tablets twice a day. -Resident #14 had his medication sent monthly, 30 or 31 tablets in each blister pack, 4 blister packs sent each month. -The "Do Not Crush" label was affixed to each blister pack. -There had been no studies to determine the possible outcome of crushing Keppra tablets. -If Resident #14 could not take Keppra in the tablet form, the facility should contact the PCP and request the medication in a liquid form.	D 358		

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D 358	Continued From page 49 Interview with Resident #14's PCP on 11/10/20 at 3:56pm revealed: -The facility staff had not informed her Resident #14 was not able to take tablets due to his diagnoses of dementia and behaviors -She did not know the MAs were crushing the Keppra tablets despite a Do Not Crush label on the blister pack. -She expected the MAs to administer medications as ordered, following the pharmacy directions on the blister pack. Interview with the Resident Care Coordinator (RCC) on 11/12/20 at 12:15pm revealed: -She supervised the MAs in the SCU. -She knew some of the residents' medications had a Do Not Crush label on their blister packs, placed there by the pharmacy. -The MAs had been trained not to crush a medication that had a Do Not Crush label affixed to the blister pack. -She did not know the MAs were crushing Resident #14's Keppra tablets that were labeled by the pharmacy as Do Not Crush. -The MAs had not informed her Resident #14 would not take the Keppra tablets whole. -If she had been informed, she would have contacted the PCP and requested the Keppra in a different form, possibly a liquid. -It was the responsibility of the MAs to inform her regarding any concerns with the residents' medications and their administration of medications. -It was her expectation the MAs would follow the directions placed on the pharmacy generated label in administering medications. Interview with the Director of Resident Care (DRC) on 11/12/20 at 9:05am revealed: -The RCC was responsible for the training and	D 358		

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D 358	Continued From page 50 oversight of the MAs administration of medications. -It was the responsibility of the RCC to oversee the administration of medications by the MAs in the SCU. -She did not know the MAs thought it was appropriate to crush medications with a Do Not Crush label if the resident would not take the medication as a tablet or capsule. -If there was a Do Not Crush label on a medication card or bottle, she would expect the MAs to report to her or the RCC if a resident was not able to take the tablet or capsule whole. -The RCC or myself would contact the provider and obtain an order for a different form of the medication. Interview with the Administrator on 11/12/20 at 1:40pm revealed: -She did not know the MAs were not administering medications as ordered and labeled by the pharmacy. -The RCC and the DRC were responsible for ensuring the training and oversight of the MAs. -Her expectation was that the MAs would follow the orders on the medication label and report to the DRC and the RCC if there was difficulty in administering the medications as ordered. Attempted telephone interviews with a second MA at 11/10/20 at 3:36pm and 11/12/20 at 11:32am were unsuccessful. Based on record review and observations, it was determined Resident #14 was not interviewable. 2. Review of Resident #4's FL-2 dated 06/09/20 revealed diagnoses included Alzheimer's disease with behavioral disturbances and metabolic encephalopathy.	D 358		

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D 358	Continued From page 51 a. Review of Resident #4's signed physician's order dated 06/09/20 revealed an order for furosemide 20mg, (a medication used to treat fluid buildup), take one tablet every other day. Review of Resident #4's subsequent signed physician's order dated 09/30/20 revealed furosemide 20mg every other day was discontinued. Review of Resident #4's October 2020 electronic medication administration record (eMAR) revealed: -There was an entry for furosemide 20mg, one tablet every other day, scheduled to be administered at 8:00am. -There was documentation furosemide 20mg was administered every other day from 10/02/20 through 10/30/20. -Furosemide 20mg was administered 15 times from 10/02/20 through 10/30/20. Review of Resident #4's November 2020 eMAR revealed furosemide 20mg was documented as discontinued on 10/30/20. Interview with the medication aide (MA) on 11/09/20 at 8:52am revealed: -She administered Resident #4 his morning medications. -She had administered furosemide 20mg every other day to Resident #4 for edema in his legs. -She knew the order had been discontinued on 10/30/20. -She did not know it was ordered to be discontinued on 09/30/20. -All orders from the physicians were processed by the nurses, the Resident Care Coordinator (RCC) and the Director of Resident Care (DRC).	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CHARLOTTE ASSISTED LIVING	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 52 -The DRC and RCC also entered all new orders and discontinued orders on the eMAR. -She did not enter or discontinue medications on the resident's eMAR. -It was the responsibility of the pharmacy staff and the RCC to complete cart audits. Interview with the pharmacist at the facility's contracted pharmacy on 11/10/20 at 3:18pm revealed: -Resident #4 had an active order for furosemide 20mg take one tablet every other day, until 10/30/20. -An order from Resident #4's primary care provider (PCP) dated 09/30/20 was sent from the facility on 10/30/20 to discontinue furosemide 20mg every other day. -As of 10/30/20 furosemide 20mg was not on Resident #4's medication profile. Interview with the PCP on 11/10/20 at 1:10pm and 11/11/20 at 4:23pm revealed: -She was recently assigned to Resident #4 as his PCP. -She was reviewing the orders from the previous provider and noted the furosemide 20mg had been discontinued on 09/30/20. -On 10/30/20 she received a physician order summary (POS) from the facility for her signature. -She noted the furosemide was still on the list of active medications and had been administered through the month of October. -She notified the facility that furosemide 20mg had been discontinued on 09/30/20. Telephone interview with the RCC on 11/12/20 at 12:15pm revealed: -She and the DRC processed physician's orders, entered new orders and discontinued orders on the eMAR.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 53 -She did not know the furosemide 20mg had been discontinued on 09/30/20 by the previous provider. -She and the DRC were given new or discontinued orders from the physician when in the facility, or faxed at a later date. -She had not seen the discontinue order that was included on the visit note of 09/30/20. -She was alerted to the discontinue order when the new PCP reviewed Resident #4's orders on 10/30/20. Telephone interview with the DRC on 11/12/20 at 9:05am revealed: -She and the RCC processed orders from the physicians. -The orders were faxed to the pharmacy. -She and the RCC then entered the new orders into the eMAR system. -She did not see the order from the PCP to discontinue Resident #4's furosemide. -She did not know how the order was missed. -She sent the discontinue order to the pharmacy when the current PCP brought it to their attention on 10/30/20. Telephone interview with the Administrator on on 11/12/20 at 1:40pm revealed: -The RCC and the DRC were responsible for processing physician's orders and entering them on the eMARS. -She did not know the discontinue order for Resident #4's furosemide was not sent to the pharmacy on 09/30/20. -She did not know Resident #4 received 15 doses of furosemide after the order was discontinued. -She expected orders to be processed when they were written by the PCP. Attempted telephone interview with a second MA	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 54 at 11/10/20 at 3:36pm and 11/12/20 at 11:32am were unsuccessful. Based on record review and observations, it was determined Resident #4 was not interviewable. b. Review of a signed physician's order dated 06/09/20 revealed an order for potassium chloride extended release ER 20mEq, (used to treat low blood levels of potassium), one tablet every other day. Review of Resident #4's subsequent signed physician's order dated 09/30/20 revealed potassium chloride ER 20mEq every other day was discontinued. Review of Resident #4's October 2020 electronic medication administration record (eMAR) revealed: -There was an entry for potassium chloride ER 20mEq, one tablet every other day, scheduled to be administered at 8:00am. -There was documentation potassium chloride ER 20mEq was administered every other day from 10/02/20 through 10/3020. Review of Resident #4's November 2020 eMAR revealed potassium chloride ER 20mEq was discontinued on 10/30/20. Interview with the first shift medication aide (MA) on 11/09/20 at 8:59am revealed: -She knew the potassium chloride ER 20mEq, one tablet every other day had been discontinued this month (November 2020). -The potassium chloride ER 20mEq, one tablet every other day was on the October 2020 eMAR. -She administered medications as they were entered on the eMAR.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 55 Telephone interview with the pharmacist at the facility contracted pharmacy on 11/10/20 at 3:18pm revealed: -Resident #4 had an active order for potassium chloride ER 20mEq, take one tablet every other day, until 10/30/20. -An order from Resident #4's primary care provider (PCP) dated 09/30/20 was sent from the facility on 10/30/20 to discontinue potassium chloride ER 20mEq, one tablet every other day Telephone interview with the PCP on 11/10/20 at 1:10pm and 11/11/20 at 4:23pm revealed: -She was reviewing the orders from the previous provider and noted the potassium chloride ER 20mEq, one tablet every other day had been discontinued on 09/30/20. -On 10/30/20 she received a physician order summary (POS) from the facility for her signature. -She noted the potassium chloride ER 20mEq, one tablet every other day was still on the list of active medications and had been administered through the month of October. -She notified the facility that the potassium chloride ER 20mEq, one tablet every other day had been discontinued on 09/30/20. -She had not ordered any follow up laboratory studies, but an increase in potassium blood levels could have a negative effect on Resident #4's heart. Telephone interview with the Resident Care Coordinator (RCC) on 11/12/29 at 12:15pm revealed: -She did not know the potassium chloride ER 20mEq had been discontinued on 09/30/20 by the previous provider. -She was alerted to the discontinue order when the new PCP reviewed Resident #4's orders on	D 358		

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D 358	Continued From page 56 10/30/20. Telephone interview with the Director of Resident Care (DRC) on 11/12/20 at 9:05am revealed: -She and the RCC entered the new orders onto the eMAR system. -She did not see the order from the PCP to discontinue Resident #4's potassium chloride ER . -She sent the potassium chloride ER discontinue order to the pharmacy when the current PCP brought it to their attention on 10/30/20. Telephone interview with the Administrator on 11/12/20 at 1:40pm revealed: -She did not know the discontinue order for Resident #4's potassium chloride ER was not sent to the pharmacy on 09/30/20. -She did not know Resident #4 received 15 doses of potassium chloride ER after the order was discontinued. -She expected orders to be processed by the clinical staff when they were written by the PCP. Attempted telephone interviews with a second MA at 11/10/20 at 3:36pm and 11/12/20 at 11:32am were unsuccessful. Based on record review and observations, it was determined Resident #4 was not interviewable. c. Review of Resident #4's signed physician's order dated 08/25/20 revealed an order for Risperdal 0.5mg, (used to treat dementia related behaviors), one half tablet every day (0.25mg). Review of Resident #4's August 2020 through November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Risperdal 0.5mg tablet,	D 358		

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D 358	Continued From page 57 one tablet daily to be administered at 9:00am. -There was documentation Risperdal 0.5mg was administered daily from 08/25/20 through 11/08/20. Review of Resident #4's prescription history from the outside pharmacy dated 11/11/20 revealed: - Risperdal 0.25mg was prescribed on 08/27/20. -The medication was sent to the facility in a 0.5mg dosage with directions to half the tablet and administer 0.25mg. Review of Resident #4's electronic Progress notes on 11/10/20 revealed: -There was documentation on 08/18/20 there was a virtual visit between Resident #4's power of attorney (POA) and a neurologist from an outside clinic. -Resident #4's recent agitation was discussed and Risperdal 0.25mg was agreed upon to administer daily. -There was documentation on 09/2/20 the in house mental health provider increased the Risperdal from 0.25mg to 0.5mg. and the POA was notified. Interview with the MA on 11/09/20 at 9:20am revealed: -She administered medications on the first shift to the residents. -She administered one tablet Risperdal 0.5mg to Resident #4 daily at 8:00am. -The medication came in bottles from another pharmacy. -She was not sure what the label read since it had been discarded when he finished the medication yesterday (11/08/20). -She went by the eMAR which instructed her to administer one tablet 0.5mg, which was what she would have administered.	D 358		

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D 358	Continued From page 58 Telephone interview with the pharmacist at the facility's contracted pharmacy on 11/10/20 at 3:18pm revealed: -Resident #4 had an active order for Risperdal 0.5mg administer daily. -The medication orders were entered on the eMAR by the facility staff. -The pharmacy staff did not enter orders or remove orders from the eMARS. -Most of Resident #4's medications were filled by another pharmacy, including Risperdal 0.25mg. -The current order for Resident #4's Risperdal 0.5mg daily was sent from the facility on a signed physician order sheet (POS) dated 10/30/20. Observation of Resident #4's medications available for administration on 11/09/20 at 11:10am revealed there were no Risperdal 0.5mg take 1/2 tablets (0.25mg) or Risperdal 0.5mg tablets in the facility. Telephone interview with the PCP on 11/10/20 at 1:10pm and 11/11/20 at 4:23pm revealed: -She did not prescribe Risperdal 0.5mg and did not see an order for that medication from the previous provider. -The order on the POS the facility sent was Risperdal 0.5mg daily. -She signed the POS on 10/30/20 with the understanding orders on the eMARS from earlier in the year were valid orders. -She could only validate orders written by providers in her company. Telephone interview with the POA on 11/12/20 at 1:30pm revealed: -He was responsible for coordinating care and medications with the outside agency. -He was able to view Resident #4's medications	D 358		

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D 358	Continued From page 59 and visits through his electronic medical chart. -He was aware the medications sent form this clinic were sent in larger doses than prescribed, and the directions on the medication label were to half the tablet. -He did not know until recently the facility was not administering the medication as ordered by halving the tablet. -He had been dissatisfied with the communication between him and the facility staff. -Emails he had sent were not answered or partially answered by the RCC and/or the Administrator. -He had requested to be consulted with all medication changes and treatment provided for Resident #4 by the prescribing provider. -He had recently been informed the mental health provider had increased the Risperdal from 0.25mg to 0.5mg. -He did not recall being consulted in that medication change. -The clinic contacted the facility to clarify the Risperdal dosage and it was communicate to the pharmacy Resident #4 was on 0.5mg. -He was told the facility MAs would not cut a tablet that was not scored, so Resident # would be receiving an even greater dosage than originally prescribed. Telephone interview with the RCC on 11/12/20 at 12:15pm revealed: -Resident #4's POA was responsible for communications with his medical providers and the pharmacy that filled his prescriptions. -The POA reviewed the medications and sent them to the facility. -She did not know the Risperdal 0.5mg was the incorrect dosage. -She did not know the pharmacy generated label on the Risperdal 0.5mg directed the tablet to be	D 358		

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D 358	Continued From page 60 halved when administered. -She thought the order had been changed by the mental health provider to Risperdal 0.5mg daily, and the POA had been notified. -It was not the policy of the facility for the MAs to cut tablets in half that were not scored by the pharmacy. Telephone interview with the DRC on 11/12/20 at 1:40pm revealed: -She did not know the Risperdal 0.5mg tablet was originally prescribed as a half tablet (0.25mg). -She knew Resident #4's outside pharmacy sent his medications to the facility. -She did know this pharmacy often sent tablets at a higher dosage and directed the tablets to be halved for administration. -She did not know Resident #4's Risperdal 0.25mg was sent in 0.5 tablets with directions to split the tablet in half to administer. -It was not the policy of the facility for the MAs to cut tablets in half that were not scored by the pharmacy. Telephone interview with the Administrator on 11/12/20 at 1:40pm revealed: -The DRC and RCC were responsible for the medication orders for the residents. -She did not know the Risperdal 0.5mg tablet was originally prescribed as a half tablet (0.25mg). -She did not know Resident #4's Risperdal 0.25mg was sent in 0.5 tablets with directions to split the tablet in half to administer. -It was not the policy of the facility for the MAs to cut tablets in half that were not scored by the pharmacy. Attempted telephone interviews with a second MA at 11/10/20 at 3:36pm and 11/12/20 at 11:32am were unsuccessful.	D 358		

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D 358	Continued From page 61 Based on record review and observations, it was determined Resident #4 was not interviewable. d. Review of Resident #4's signed physician's order dated 08/18/20 revealed an order for Namenda 5mg daily, (used to treat dementia). Review of Resident #4's August 2020 through November 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Namenda 5mg, one tablet daily, to be administered at 9:00am. -There was documentation Namenda one tablet was administered daily from 08/25/20 through 11/08/20. -Namenda was documented as administered to Resident #4 82 times from 08/19/20 through 11/08/20. Observation of the medications available for administration on 11/09/20 at 11:00am revealed: -There was a medication bottle with a pharmacy generated label Memantine HCL (Namenda) 10mg tablet, take ½ tablet daily. -There were 45 tablets sent on 08/19/20 with 2 refills, and the tablets were not scored. Resident #4's pharmacy prescription history dated 11/11/20 revealed Namenda 10mg, take ½ tablet daily, was filled on 08/19/20, for a quantity of 45 tablets with 2 refills. Interview with the MA on 11/09/20 at 9:20am revealed: -She administered medications on the first shift to the residents. -She administered one tablet of Namenda . -The eMAR entry Namenda 0.5mg 1 tablet to be administered daily.	D 358		

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D 358	Continued From page 62 -She did not notice the pharmacy generated label stated Namenda 10mg take one half tablet daily. -She went by the eMAR that stated 1 tablet daily. -She did not notice the difference in dosages. -It was not the policy of the facility to cut tablets in half. Telephone interview with the RCC on 11/12/20 at 12:15pm revealed: -She did not look at the pharmacy generated label on the bottle and the eMAR entry before giving them to the MA. -She relied on the MAs to read the directions on the blister pack or bottle of the resident's medications before administering. -The MAs had not reported the directions were to halve the tablet before administering. -She did not know the MAs were administering 10mg daily instead of 5mg as ordered. -It was not the policy of the facility to cut tablets in half. Telephone interview with the DRC on 11/12/20 at 1:40pm revealed: -She did not know Resident #4's Namenda tablets were 10mg with directions to half the tablet and administer Namenda 5mg daily. -She did not know the tablets were not scored. -It was not the policy of the facility for the MAs to cut tablets in half that were not scored by the pharmacy. -She did not know the MAs were administering Namenda 10mg instead of the prescribed 5mg order. -She expected the MAs to inform the RCC or herself if the medication delivered from the pharmacy did not match the order on the eMAR. -There was no system in place to consistently monitor the medications and the eMAR entries. -She had been relying on the pharmacist from the	D 358		

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D 358	Continued From page 63 facility's contracted pharmacy who had been completing monthly medication cart audits before April 2020. Telephone interview with the Administrator on 11/12/20 at 1:40pm revealed: -The DRC and RCC were responsible for the medication orders for the residents. -She did not know Resident #4's Namenda 5mg tablet was sent in a 10mg tablet with directions to split the tablet in half to administer. -It was not the policy of our facility for the MAs to cut tablets in half that were not scored by the pharmacy. Telephone interview with the POA on 11/12/20 at 1:30pm revealed: -He was responsible for coordinating care and medications for Resident #4. -He was able to view Resident #4's medications and visits through his electronic medical chart. -He was aware the medications sent from the outside pharmacy were sent in larger doses than prescribed, and the directions on the medication label were to half the tablet. -He did not know until recently the facility was not administering the medication as ordered by halving the tablet. -He did not know it was the facility's policy that MAs could not cut a tablet or pill that was not scored. Attempted telephone interviews with a second MA at 11/10/20 at 3:36pm and 11/12/20 at 11:32am were unsuccessful. Based on record review and observations, it was determined Resident #4 was not interviewable. 3. Review of Resident #1's current FL2 dated	D 358		

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D 358	Continued From page 64 10/14/20 revealed diagnosis included seizure activity. Review of hospital discharge summary dated 10/02/20 revealed: -Resident #1 was admitted to the hospital on 09/28/20 presenting with diarrhea and abdominal pain. -Resident #1's primary diagnosis was colitis (an inflammatory reaction in colon). Review of Resident #1's progress notes revealed: -On 09/25/20 at 11:19am, the resident was having several loose stools, the resident was given loperamide (used to treat diarrhea) for diarrhea. -On 10/04/20 at 5:55pm, the resident was having continuous loose bowel movement, staff assisted resident with toileting. Review of Resident #1's signed physician's orders revealed: -There was a typed document titled "ALF Standing Orders". -There were instructions listed for diarrhea. -The was no resident name listed on the document. -A physician's name was typed at the end, however there was no signature. -There was an order dated 10/30/20 for loperamide 2mg one capsule after each loose bowel movement, no more than 16mg in 24 hours. Interview with the pharmacist at the facility's contracted pharmacy on 11/05/20 at 4:38pm revealed: -Physician orders were received via fax from the facility. -The pharmacy had not received any order for	D 358		

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D 358	Continued From page 65 loperamide for Resident #1. -Loperamide was not usually supplied by the pharmacy, it was usually bought by the facility and used as needed by the staff according to physician orders. Review of Resident #1's electronic Medication Administration Record (eMAR) for August, September, and October 2020 revealed: -There was no entry for loperamide 2mg. -There was no documentation loperamide 2mg had been administered. Review of Resident #1's November 2020 eMAR revealed: -There was an entry for loperamide 2mg one capsule after each loose bowel movement, no more than 16mg should be taken in 24 hours. -There were no documented administrations for loperamide. Observation of Resident #1's medications available for administration on 11/06/20 at 4:06pm revealed there was a bottle of loperamide 2mg labeled "house stock" available for administration. Interview with Resident #1's Responsible Party (RP) on 11/03/20 at 2:55pm revealed: -Resident #1 frequently had loose stools and diarrhea. -She would receive phone calls from the staff regarding loose stools and ask staff why they did not administer loperamide. -Some staff responded that they gave one tablet per day, however she was told during phone calls with staff that the diarrhea would persist. Telephone interview with a medication aide (MA) on 11/12/20 at 12:47pm revealed:	D 358		

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D 358	Continued From page 66 -Resident #1 had diarrhea during some shift she worked over the past three months. -She administered loperamide to Resident #1, however did not document it on the eMAR. -She gave Resident #1 the loperamide according to the instructions on the bottle. -There was nowhere to document that she gave loperamide on the eMAR. -The Resident Care Coordinator (RCC) had the standing orders and informed that she could administer as it was on the standing order. Telephone interview with a second MA on 11/12/20 at 12:50pm revealed: -Resident #1 would frequently have loose stools and diarrhea. -She administered loperamide to Resident #1 within the past 3 months. -There was not a place on the eMAR to document when she administered loperamide. -She administered loperamide "a few times" according to the instructions on the bottle. -She was told by the RCC that there was a standing order for loperamide, however she had not seen the order. Interview with a third MA on 11/09/20 at 10:50am revealed: -Resident #1 had several episodes of diarrhea. -When she worked, she would administer loperamide to Resident #1 when she had loose stools. -She documented in the progress notes on 09/25/20 at 11:19am that loperamide was administered to Resident #1. -There was not a place on the eMAR to document when she administered loperamide. -She was told by the RCC that there was a standing order for loperamide, however she had not seen the order.	D 358		

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D 358	Continued From page 67 -She notified the RCC when she had to administer loperamide to Resident #1. Interview with the RCC on 11/05/20 at 11:07am revealed: -She was responsible for communicating to the primary care physician (PCP) with any concerns or issues with residents. -She knew Resident #1 had intermittent diarrhea and followed the facility standing orders. -She did not know the standing orders needed to be signed by the physician and include the resident's name. -She informed MAs that they could administer medications according to the standing order for diarrhea because she thought it was a valid order. Interview with the nurse for Resident #'1's Neurologist on 11/10/20 at 10:37am revealed: -Resident #1 had a virtual visit on 10/29/20. -The RCC informed physician of intermittent diarrhea and requested an order for loperamide. -The physician wrote the order for loperamide, however recommended that she be seen by gastroenterology for any further stomach issues. -Prior to 10/29/20, there was no discussion with staff regarding diarrhea or the need for loperamide. Interview with the Administrator on 11/12/20 at 3:15pm revealed: -She expected medications to be administered as ordered by the physician. -MAs were not allowed to administer medications without an order. -She did not realize the standing orders did not include residents' names or physician signatures. -She expected all orders to include the resident name and physician signature.	D 358		

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D 358	Continued From page 68 -The RCC was responsible for ensuring all orders were signed and dated by the PCP. The facility failed to administer medications as ordered as related to Keppra being administered as ordered (Resident #14); continuing to administer medications that were discontinued and administering the wrong dosage of Risperdal and Namenda (Resident #4) putting the resident at risk for a risk of falls due to sedation and administering loperamide to Resident #1 without signed physicians' orders. This failure to ensure medications were administered as ordered was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on November 30, 2020 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 27, 2020.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure residents received care	D912		

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D912	Continued From page 69 and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care and medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up with the licensed practitioner for 1 of 3 sampled residents (Resident #1) related to a physical therapy (PT) referral and notification of weight loss. [Refer to Tag 0273 10A NCAC 13F .0902 Health Care (Type B Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered for 1 of 4 residents observed during the medication pass, including an error with a medication used to treat seizures (Resident #14); and for 2 of 5 sampled residents for record reviews including medications used to treat behaviors and dementia, a medication used to treat fluid build up, a medication used to treat low blood levels of a mineral (Resident #4); and a medication used to treat diarrhea (Resident #1). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912	131D-21 (2) Declaration of residents rights. Please see plans of action under 10A NCAC .0901, .0902 & .0909, completed on or before by RCD/RCC + Clinical staff.	12/5/20
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by:	D914		

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D914	Continued From page 70 Based on interviews and record reviews the facility failed to ensure residents were free from neglect related to Resident Rights and Supervision. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents and to reduce the risk of transmission and infection during the global coronavirus (COVID-19) pandemic as related to rapidly taking action to test staff and all residents and retesting of staff and residents that were negative for COVID-19 weekly after an outbreak; a staff only being tested once from August to October 2020 (Staff G); residents admitted during the COVID-19 outbreak from 08/06/20 through 10/26/20 with recommendations from the LHD to stop admissions; and accommodating compassionate care visits for a resident with significant weight loss and decline (Resident #1). [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure staff provided supervision for 1 of 5 sampled residents, (Resident #5), as related to staff not ensuring a resident, who resided in the Special Care Unit (SCU), was supervised while ambulating, which led to a fall and hospitalization. [Refer to Tag 269 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].	D914		

Division of Health Service Regulation

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12/22/20 Kelsi Workman, Executive Director