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
	HAL060132	A. BUILDING: ______ B. WING ______	R 07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SOCIAL AT COTSWOLD	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual and follow-up survey and a complaint investigation on 07/07/21 through 07/09/21, 07/12/21 with an exit date of 07/13/21.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the floors and floor coverings were kept clean and in good repair in the common areas and hallways in both the assisted living floors and the Special Care Unit (SCU), related to a resident's bedroom on the first floor that had brown staining and dried liquid staining on the carpets, dried brown staining on the mattress and box spring, and a strong smell of urine and feces (Resident #6 and #21), two additional bedrooms with a pungent odor of urine (Resident #7 and #3), urine puddled on the floor with paper towels over the urine (Resident #3), and a hole in the ceiling in the common area where residents congregate to watch TV and a large dried water stain on the rug below.	D 074		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Cheryl Withrow, Interim Executive Director Acting
TITLE
(X6) DATE 8-24-21

Karen M Poles Reviewed / acknowledged 9-3-21

The Social at Cotswold
Plan of Correction
License #: HAL-060-132

The following Plan of Correction is prepared and submitted by The Social at Cotswold, as mandated by State regulations. However, this response does not constitute agreement with the allegations or citations specified on the Statement of Deficiencies. The Social at Cotswold maintains that the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by applicable regulations.

D074 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings

1. Immediate action: Resident #7's carpet to be replaced by 8/31/21. Resident #6's mattress was removed and replaced due to odor.
2. By 8/31/21, the Maintenance Director and the Regional Director of Facility Operations or designee will complete a walk-through of community, going room by room, to assure room is maintained and free of odor as per regulatory standards. Immediate plan, with appropriate timeline for completion, will be put into place to address any areas of opportunity observed during their walk-through of resident apartments and common areas. Further renovations to Memory Care (SCU) are scheduled to be completed by 10/31/21.
3. The Regional Director of Facility Operations (RDFO) and Maintenance Director completed a "Weekly Housekeeping Assignment" schedule to assure each apartment is cleaned at least weekly. The housekeeping staff were trained to the Weekly Housekeeping Schedule and reporting areas of concern timely on 7/29/21. The Regional Director of Facility Operations will provide in-service training to Maintenance Director on completing a weekly housekeeping audit that will be completed on 10 random apartments and common areas. This process started 8/5/21. The Maintenance Director will provide in-service training to community staff on completing a maintenance work order to assure observed concerns are addressed timely. This training will be completed by 9/1/21. The Regional Director of Health and Wellness and/or VP of Health and Wellness will complete in-service training with the Interim Executive Director, Interim Health and Wellness Director, and community nursing staff on completing rounds as it pertains to Housekeeping, Maintenance, and Risk Management. This training will be completed by 8/27/21.
4. It is the responsibility of housekeeping and maintenance staff to assure the community is appropriately maintained and free of odor. Until areas of opportunity have been appropriately addressed from initial walk-through, the Interim ED, Regional Director of Facility Operations, and/or designee will conduct weekly review of areas identified to assure they are completed within timeline that was set. Beginning 8/23/21, the Interim Health and Wellness Director and/or designee along with the Memory Care Coordinator (MCC) will complete daily compliance rounds as it pertains to Housekeeping, Maintenance and Risk Management. Completed Compliance Round Checklist will be provided to the Interim ED for review. If needed, immediate interventions will be put into place to address any areas of opportunity and trainings will be conducted as needed. The Interim ED will monitor completion of compliance rounds for 60 days. Beginning 9/1/21 the Maintenance Director will complete random audits of 10 resident apartments weekly to assure it is clean and free odor. Beginning 9/6/21, the Interim ED and/or designee will complete a weekly random review of closed work orders to assure they have been completed to regulatory standards. Continued areas of opportunity will be appropriately addressed via corrective action up to termination of employment as warranted.

D113 10A NCAC 13F .0311(d) Other Requirements (Water Temps) Type B

1. Immediate Action: On 7/8/21, the Maintenance Director (MD) adjusted the hot water temperature to be between 100 -116 degrees F per regulatory standards. Weekly checks will be completed by MD or designee and notes will be documented into TELS. Executive Director (ED) will review the logs weekly and act accordingly.
2. Hot water temperatures have been monitored weekly since 7/19/21 in resident apartments and common areas. Reported temperatures since 7/19/21 have not been above 116 degrees F and adjustments were made for any temperatures observed below 100 degrees F, temperature was rechecked immediately, and an appropriate water temperature was documented.
3. The Regional Director of Facility Operations provided training to MD on completing and documenting weekly water temperature monitoring to Weekly Temperature Log and maintaining water temperatures per regulatory standards.
4. The Maintenance Director is responsible for monitoring water temperatures per regulatory standards. Weekly Water Temperature Log will be completed, and information will be documented in TELS. Water temperatures above regulatory standard will be immediately addressed. For the next 90 days the Interim Executive Director and/or designee will review Weekly Temperature Log to assure hot water is maintained between 100-116 degrees F per regulatory standard. Water Temperature Regulator will be installed to hot water system by 10/31/21.
5. Moving forward water temperatures will be monitored and documented as required.

D137 10A NCAC 13F .0407(d) Other Staff Qualifications (Health Care Personnel Registry)

1. The Health Care Personnel Registry was reviewed for staff members A, B, C, D, and E to assure no substantiated findings are listed. A copy of the findings is available for review.
2. An audit will be conducted of current employee files to assure that the Health Care Personnel Registry has been pulled and reviewed for any substantiated findings per regulatory standards. This audit will be completed by 8/31/21. Any files observed during audit without Health Care Personnel Registry review, will be updated immediately to assure regulatory compliance. Moving forward, for all new hires, the Health Care Personnel Registry will be reviewed and printed for the employee file prior to start date. Staffing agencies have been contacted and have provided proof that their current employees, currently utilized in the community, have documentation of Health Care Personnel Registry
3. The Regional Director of Health and Wellness (RDHW) will provide in-service training to Interim ED and Community Business Director on where and how to access the Health Care Personnel Registry to include the requirement to print findings for employee file for current employees and new hires. This training will be completed on or before 8/27/21.
4. The Community Business Director (Business Office Manager) or designee will conduct a Health Care Personnel Registry review for new hire employees. For the next 60 days, the Interim ED or designee will complete a review of new hire employee records, hired after 8/20/21, to assure that the Health Care Personnel Registry review has been conducted and is available. Concerns will be immediately addressed to include Corrective Action up to termination of employment.
5. Moving forward the Community Business Office Manager (Business Office Manager) or designee will conduct an audit quarterly for those employees hired during that quarter to assure the Health Care Personnel Registry record print-out is available to assure continued regulatory compliance.

D139 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Criminal Background)

1. A criminal background check was completed for staff members A, B, C, D, and E in accordance with G.S. 114-19.10 and 131D-40. A copy of the information can be found at the community.
2. An audit will be conducted, by the Community Business Director, of current employee files to assure that the criminal background check has been pulled and reviewed per General Statute and regulatory standard. This audit will be completed by 8/31/21. Any files observed during audit without a criminal background check, will be updated immediately to assure regulatory compliance.
3. The Regional Director of Health and Wellness (RDHW) will conduct in-service training with Interim ED and Community Business Director as it pertains to regulatory standard on conducting criminal background check per G.S. 114-29-.10 and 131D-40. This training will be completed on or before 8/27/21.
4. Prior to start date, the Community Business Director or designee will conduct a criminal background check and review findings with Interim ED or administrator in charge, if needed. For the next 60 days, the Interim ED or designee will complete a review of new hire employee records, hired after 8/27/21, to assure that the criminal background check has been conducted and is available prior to start date. Concerns will be immediately addressed to include corrective action up to termination of employment.
5. Moving forward the Community Business Office Manager (Business Office Manager) or designee will conduct an audit quarterly of staff hired during the quarter to assure the criminal background check is available per regulatory standard

D161 10A NCAC 13F .0504(a) Competency Validation for LHPS Tasks

1. Staff members A, D, and E have had Competency Validation for LHPS Tasks completed and is available for review.
2. The Community Business Director will conduct an audit of employee files to assure that a Competency Validation for LHPS Tasks has been completed for non-licensed team members by 8/31/21. If not available, Competency Validation for LHPS Tasks will be completed for current staff by 9/15/21 by RN or other approved provider per regulatory standard.
3. The Regional Director of Health and Wellness or VP of Health and Wellness will provide in-service training to Interim ED, Interim HWD, and other hiring managers for health and wellness department to assure understanding that new hire non-licensed direct care staff must have Competency Validation for LHPS Tasks completed by RN or other approved provider, per regulatory standard, prior to performing the task alone along with ongoing validation through observation. This training will be completed by 8/25/21.
4. The Health and Wellness Director and Memory Care Coordinator are responsible for assuring that Competency Validation of LHPS Tasks is completed prior to non-licensed direct care staff member completes task alone. Over the next 60 days the Executive Director (Interim ED) will be provided the Competency Validation for LHPS Tasks for new hire and current residents to assure they are being completed timely and signed. Moving forward the Community Business Director will conduct an audit quarterly of those staff members hired during that quarter to assure that Competency Validation is available and completed.

D234 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination, and Immunizations

1. The 2nd step PPD was placed and read for Resident #1 and #2 and appropriately documented in the resident file
2. An audit of current resident files will be conducted to assure appropriate documentation of 2-Step Mantoux test or other TB testing approved for compliance with the control measures for the Commission for Health Services is available. This audit will be completed by 9/10/21. Areas of compliance opportunity observed during the audit will be corrected to assure community continues to meet regulatory standards
3. The Regional Director of Health and Wellness or VP of Health and Wellness will provide in-service training to ED and HWD regarding testing for tuberculosis disease as per regulatory standards. This training will be conducted on or before 8/31/21.
4. It is the responsibility of the ED and HWD to assure that the resident has been appropriately tested for tuberculosis disease in compliance with the DHHS Tuberculosis Control Program. For the next 30 days, the Executive Director will monitor new move-ins to assure that appropriate documentation is received prior to admission and, if warranted, completed 7-14 days after admission and available in resident file.
5. Moving forward regular, random audits of resident's files will be completed to assure continued compliance with tuberculosis testing as required per regulatory standards.

D269 10A NCAC 13F .0901(a) Personal Care and Supervision (Care Needs) Type A2

Immediate Action: On 7/15/21 all care team members were trained by ED and community nurse team on ADLs for resident and the call bell system. Manager Rotation in place (Leader of the Day) on all shifts to verify residents are receiving care services. ED or designee will verify care needs being met by checking resident once per week by looking at call bell system dashboard and speaking directly with residents. Wellness checks initiated for verification of care on 7/14/21 by ED and nurse team.

1. A reassessment and review of current care plan was completed for Residents #3, 4, and 9 to assure residents current care needs appropriately documented and being met.
2. The Interim Health and Wellness Director and/or designee will complete care rounds on current residents to assure that assessed and care planned needs are appropriately included on the staff's assignment sheets and being met per regulatory standards. These initial rounds will be completed by 8/31/21.
3. The Health and Wellness Director and/or VP of Health and Wellness will conduct in-service training with the Assistant HWD and Memory Care Coordinator on the completion of Daily Caregiver Rounds to assure care is being provided as assessed and per residents' needs. This training will be completed by 9/1/21. The Health and Wellness Director and/or VP of Health and Wellness will complete in-service training with current direct care staff on Completion of ADL Tasks to include Reporting a Change of Condition; training will also include review of policies "Emergency Call System – North Carolina" and response time expectations to assure resident's needs are being met timely; training will also include review of Compliance and Caregiver Rounds that will be conducted to assure continued compliance. Training will be completed by 9/1/21.
4. It is the responsibility of the aides, supervisors in charge, and community leadership to assure resident's care needs are being tended to and met daily per assessed and care planned needs. Beginning 9/6/21, the Assistant HWD and Memory Care Coordinator, or designees will complete daily documented care rounds to assure care is being provided per resident's care plan, areas of opportunity will be addressed immediately to assure continued compliance. For the next 60 days, the HWD will review the care rounds weekly and will complete a random review of residents to assure care is being completed. Continued areas of opportunity will be addressed to include corrective action up to termination of employment. Moving forward care rounds will be completed by community nursing staff and areas of opportunity will be appropriately addressed to assure care needs are being met.

D270 10A NCAC 13F .0901 Personal Care and Supervision (Safety) Type A1

1. Immediate Action: Resident #6 transferred to Special Care Unity (SCU) on 7/14/21 and moved out of community on 8/6/21 due to change in condition. Resident #3, #4 and #5 have moved to SCU. On 7/15/21 all team members in serviced on elopement policy by Thrive QA Analyst and Executive Director. On 7/16/21 elopement drill was conducted by MD with the entire team. On 7/22, 7/29, and 8/6/21, additional elopement drills were conducted by MD. Weekly drills will be conducted until 10/15/21 by MD. Starting 7/11/21, 15-minute checks initiated on 2 residents with a cognitive decline by care team and documented.
2. The Interim Health and Wellness Director, community nursing staff and/or designee will complete Mini Mental Status Exams (MMSE) and Elopement Risk Assessments on current residents residing in assisted living (non-secured). This reassessment will be completed by 8/27/21. Residents identified to be at risk for elopement will be discussed with physician and family for a potential move to SCU or other appropriate interventions.
3. The Regional Director of Health and Wellness and/or VP of Health and Wellness will complete in-service training with the Interim ED, Interim Health and Wellness Director, and community nurse managers on completing Elopement Risk Assessment on residents at move-in, quarterly and with significant change of condition, and MMSE on residents at move-in and with significant change of condition. This training will be completed by 8/27/21. The Interim Executive Director and Interim Health and Wellness Director will conduct training with community staff on recognizing and reporting change of conditions and how to complete an appropriate safety check. This training will be completed by 8/31/21.
4. It is the responsibility of the Interim ED and Community nurse managers to assure appropriate placement of residents based on physician recommendation and elopement risk assessment. Over the next 90 days the Executive Director will review MMSE and Elopement Risk Assessments on new move-ins and current residents to assure appropriate placement; residents of concern will be discussed with physician and the family to discuss potential placement to SCU and/or other appropriate interventions. Moving forward new hire staff will be provided training to Elopement Policy and Elopement Drill procedures, and a review of Elopement Policy and an Elopement Drill will be completed at least quarterly and as needed.

D276 10A NCAC 13F .0902(b) Health Care

1. Actions completed to assure immediate compliance include all physician visit notes have been provided to the community starting 7/15/21 and filed in the resident charts. Physician notes will be reviewed by the community nurse effective immediately and ongoing. Resident concerns will be documented in the communication log and will be reviewed by the community nurse effective immediately and ongoing. A nurse will follow-up by checking communication log daily and general care notes daily and initiate any follow-up as needed.
2. The Interim Health and Wellness Director and community nursing staff will complete a review of current resident files to assure that appropriate referrals and follow-up have occurred since 7/15/21. Areas of opportunity will be appropriately addressed.
3. The Regional Director of Health and Wellness and/or VP of Health and Wellness will provide in-service training to Interim Executive Director, Interim Health and Wellness Director, and community nursing staff on company policies to assure health care needs of residents are being met. Policies that will be reviewed during training are Resident Referral to Ancillary Healthcare Provider Policy, Acute Illness Policy, and Medication Administration Policy. This training will be completed by 8/27/21. The Health and Wellness Director will provide in-service training to the above listed policies to direct care staff to assure continued regulatory compliance. Training will be completed by 8/31/21.
4. It is the responsibility of the community nursing staff to assure the routine and acute health care needs of the resident are met per regulatory standard. Over the next 30 days, until 10/1/21, the Health and Wellness Director will complete a weekly review of orders and documentation to assure appropriate initiation and follow-up of physician orders and referral needs has occurred. Moving forward, ongoing review of resident files, to include nursing care notes, to assure appropriate initiation and follow-up of physician orders and referral needs has occurred.

D338 10A NCAC 13F .0909 Resident Rights Type A2

Immediate Action: As of 7/15/21 all team members trained on resident rights by the QA Analyst. The Ombudsman contacted and agreed to do a Resident Rights training with the team on 8/26/21. Executive Director and management team will continue with Wellness Checks on random residents routinely. Resident Council meets monthly and led by the Social Network Director and notes maintained. Quarterly, the team will be trained on Resident Rights through RELIAS. This will be monitored by the Community Business Director.

1. Residents #1 and #6 no longer reside at the community. Resident #13 is being treated with respect, consideration and dignity related to assistance with care needs. Resident #5 is being treated with respect, consideration and dignity and now resides in the Special Care Unit (SCU). Resident #9 is being treated with respect, consideration and dignity and is being assisted with transfers as needed. Resident #12 is being treated with respect, consideration and dignity and the call light is being responded to meet care needs.
2. The Interim Health and Wellness Director or Community Nurse designee will complete a review of current resident files to assure appropriate placement and care plans are in place. Resident concerns will be documented in the communication log and will be reviewed by the community nurse. The Community Nurse or designee will review the 24-hour report sheet/communication log daily for changes of condition, changes of behavior, and care concerns to initiate any follow up and report as needed, effectively immediately and ongoing. Areas of compliance opportunity will be corrected to assure community continues to meet regulatory standards.
3. The Regional Director of Health and Wellness or VP of Health and Wellness will provide in-service training to the Interim Executive Director, Interim Health and Wellness Director, and Community Nurses regarding treating residents with respect, consideration, and dignity as it relates to assessed needs and care plan. The policy that will be reviewed is the Resident Rights Policy. This training will be completed on or before 8/31/21.
   The Interim Health and Wellness Director or Community Nurse designee will provide in-service training to the clinical staff regarding treating residents with respect, consideration, and dignity as it relates to assessed care needs and care plan. The policy that will be reviewed is Resident Rights Policy. This training will be completed on or before 8/31/21.
4. It is the responsibility of the aides, supervisors in charge, and community leadership to assure resident's care needs are being tended to and met daily per assessed and care planned needs. Education and training on the Resident