DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: HAL- 060-150	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	DATE SURVEY COMPLETED: 10/05/22

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

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)	COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey on 10/04/22 to 10/05/22.	D 000		
D 238	10A NCAC 13F .0703(c-4) Tuberculosis Test, Medical Examination and Immunizations 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination and Immunizations The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. This Rule is not met as evidence by: Based on record reviews and interviews, the facility failed to ensure a resident's FL-2 included complete information and was clarified by the primary care provider (PCP) for 1 of 2 sampled residents (#3) who had no diagnosis listed on the current FL-2. The findings are:	D 238		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

Executive Director 11/10/22

Reviewed & Acknowledged
-Nicola G. Hill 11/21/22

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D 238	Continued From page 1 Review of Resident #3's current FL-2 dated 05/18/22 revealed: -Recommended level of care was assisted living. -There was no documentation of medical diagnosis for Resident #3. -Medications were listed as Amlodipine 10mg 1 tablet daily (used to treat high blood pressure), Daily-Vite 400mg 1 tablet daily (used for vitamin replacement), Donepezil 10mg 1 tablet daily (used to treat Alzheimer's disease symptoms), Namenda 10mg 1 tablet twice a day (used to slow the progression of Alzheimer's disease), Quetiapine 50mg 1 tablet daily and Quetiapine 50mg 1 tablet as needed (used as an antipsychotic treatment). -Resident #3 disorientation was intermittent. -Resident #3 was incontinent in bladder and continent in bowel. -The FL-2 was signed by the Primary Care Provider (PCP) on 05/18/22. Review of Resident #2's previous hospital generated FL-2 dated 02/22/22 revealed: -Diagnosis included major neurocognitive disorder secondary of Alzheimer's dementia and bacteria acute nonplaced fracture across left greater isochrone and small bilateral inguinal hernia. -Medications were listed as taking Amlodipine 10mg 1 tablet daily, Multivitamin 1 tablet daily, Donepezil 10mg 1 tablet daily, Quetiapine 50mg 1 tablet daily and Acetaminophen 650mg as needed.	D 238		

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D 238	Continued From page 3 -Resident #3 disorientation was intermittent. -Resident #3 was incontinent in bladder and continent in bowel. Interview with the PCP on 10/05/22 at 1:47pm revealed: -She had not completed the FL-2 for Resident #3. -The Special Care Coordinator (SCC) had Completed Resident #3's FL-2 and faxed to her office for review and signature. -She signed Resident #3's FL-2. -The PCPs assistant reviewed Resident #3's FL-2 and she signed off on the FL-2. -She had not noticed the diagnosis on Resident #3's FL-2 had not been completed. Interview with the SCC on 10/05/22 at 3:00pm revealed: -She had completed Resident #3's FL=2 and submitted it for review and signature to the PCP. -Her not documenting the diagnoses on Resident #3's FL-2 was an oversight. -Resident #3's diagnosis was noted on the computerized charting system and was used as a guide. -She was responsible for completing the FL-2 and submitting the FL-2 to the PCP. Interview with the Executive Director on 10/05/22 at 3:28pm revealed: -She expected the FL-2s to be complete.	D 238		

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D 238	Continued From page 4 -Information that does not apply to a resident should be noted on the FL-2 as "not applicable" (n/a). -She completed audits on residents' records every 5 months. -The last audit was compieted in July 2022. -The SCC was responsible for completing the FL-2s and submitting it to the PCP for review and signature.	D 238		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904(f)(2) Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide feeding assistance with dignity and respect for 2 of 5 sampled residents (#1, #5) related to staff standing while feeding residents. The findings are: 1. Review of Resident #1's current FL-2 dated	D 312		

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D 312	Continued From page 4 01/07/22 revealed diagnoses included vascular dementia, malignant neoplasm of the pancreases, heart disease, and hypertensive chronic kidney disease. Review of Resident #1's care plan dated 02/03/22 revealed he required limited assistance for eating. Review of Resident #1's hospice orders dated 09/28/22 revealed he was on a regular diet with pureed texture. Observation of the lunch meal on 10/04/22 at 12:00pm revealed: -Resident #1 was sitting in a Geri chair (a large, padded chair designed to help residents with limited mobility and can also recline). -The Geri chair was positioned in the upright position with the footrest in the down position and resident's feet pushed under the dining table. -Staff was standing while providing feeding assistance to Resident #1. Interview with the personal care aide (PCA) on 10/05/22 at 3:08pm revealed: -She did not recall being trained on providing feeding assistance at eye level to a resident to promote dignity and respect. -She understood that providing feeding assistance while standing could make the resident feel hurried and not respected.	D 312		

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D 238	Continued From page 5 -She should have provided feeding assistance to Resident #1 at eye level. Refer to interview with a medication aide (MA) on 10/05/22 at 8:15am. Refer to interview with a second MA on 10/05/22 at 10:32am. Refer to interview with the Special Care Coordinator (SCC) on 10/05/22 at 3:18pm. Refer to interview with the Executive Director (ED) on 10/05/22 at 3:29pm. 2. Review of Resident #5's current FL-2 dated 07/14/22 revealed: -Diagnosis included Alzheimer's disease. -Resident #5 required limited assistance with eating. Review of Resident #5's Care Plan dated 12/21/21 revealed the resident required limited assistance with eating. Observation of the lunch meal on 10/04/22 at 12:00pm revealed: -Resident #5 was sitting in a Broda chair (a special wheelchair capable of reclining to promote positioning, safety, pressure relief, and correct posture). -The wheelchair was positioned lengthwise parallel to the dining table and was in a semi-	D 238		

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D 238	Continued From page 6 reclining position with the footrest up. -Staff was providing feeding assistance to Resident #5 while standing beside the chair. Observation of the breakfast meal on 10/05/22 at 8:00am revealed: -Resident #5 was sitting in the Broda chair. -The wheelchair was positioned lengthwise parallel to the dining table and was in a semi-reclining position with the footrest up. -Staff was standing beside the chair while providing feeding assistance to Resident #5. Interview with the second PCA on 10/05/22 at 8:10am revealed: -She had been trained to provide feeding assistance to residents at eye level to promote dignity and respect. -She did not provide feeding assistance to Resident #5 at eye level because the resident was in a Broda chair. -She would have had to position the chair under the table tor her to place a chair beside the resident to provide feeding assistance at eye level. Interview with the medication aide (MA) on 10/05/22 at 8:15am revealed: -The Broda chair can be positioned to place the resident's feet under the table in the dining area so staff could sit beside the resident and provide feeding assistance at eye level. -The staff should have positioned the chair under	D 238		

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D 238	Continued From page 7 under the table to provide eye level feeding assistance to the resident. -She did not know why staff did not lower the footrest and position the resident's feet under the dining table. Refer to interview with a medication aide (MA) on 10/05/22 at 8:15am. Refer to interview with a second MA on 10/05/22 at 10:32am. Refer to interview with the Special Care Coordinator (SCC) on 10/05/22 at 3:18pm. Refer to interview with the Executive Director (ED) on 10/05/22 at 3:29pm. Interview with the medication aide (MA) on 10/05/22 at 8:15am revealed she was aware that staff should provide feeding assistance to residents at eye level to promote dignity and respect. Interview with a second MA on 10/05/22 at 10:32am revealed: -She was aware that residents should be provided feeding assistance at eye level for dignity and respect. -She observed staff providing feeding assistance to residents while standing. -She should have instructed the staff to sit at eye	D 238		

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D 238	Continued From page 8 level to the residents while providing feeding assistance. -She did not know if staff providing the feeding assistance to residents had been trained to provide feeding assistance at eye level to promote dignity and respect. Interview with the Special Care Coordinator (SCC) on 10/05/22 at 3:18pm revealed: -She was not aware that staff did not provide feeding assistance to residents at eye level to promote dignity and respect. -Staff had been trained on providing feeding assistance to the residents by the Licensed Health Professional Support (LHPS) Tasks nurse. -She expected staff to provide feeding assistance to residents at eye level and in an unhurried manner to promote dignity and respect. Interview with the ED (Executive Director) on 10/05/22 at 3:29pm revealed: -She was surprised that staff did not sit at eye level while providing feeding assistance to residents at eye level. -She did not know if staff had been trained on providing feeding assistance to residents at eye level. -She expected staff to provide feeding assistance to residents while sitting at eye level to promote an atmosphere of dignity and respect.	D 238		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 9 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription; and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 6 residents (#1, #6) observed during the medication pass including errors with a medication for nerve pain (#1) and depression (#6). The findings are: Review of the facility's Medication Administration Policy dated 09/21 revealed: -The community provides medication administration, ordering and reordering of medication and medication administration services. -Missed or refused medications are documented in the resident's medication administration record (MAR) and the provider, responsible party is notified, and it is documented. -Medications may be given up to one hour before or up to one hour after the prescribed	D 358		

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D 358	Continued From page 10 time unless the physician orders an exact time. Review of the facility's Cart Audit/Medications on Hand Review policy dated 09/21 revealed: -Facility will develop a schedule so that all resident medication orders are checked on a weekly basis by completing a cart audit. -Staff will check to see that all medications are available using a copy of the physician's orders. The medication error rate was 7% as evidenced by the observation of 2 errors out of 26 opportunities during the 8:00am medication pass on 10/04/22. 1. Review of Resident #1's current FL-2 dated 01/17/22 revealed diagnoses included vascular dementia, malignant neoplasm of the pancreas, heart disease, and hypertensive chronic kidney disease. Review of Resident #1's physician orders dated 09/23/22 revealed there was an order for Gabapentin 100mg three times a day (Gabapentin is a medication used to treat nerve pain). Observation of the 8:00am medication pass on 10/04/22 revealed: -The medication aide (MA) prepared and administered three medications to Resident #1 at 8:45am. -Gabapentin was not offered or prepared and	D 358		

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D 358	Continued From page 11 administered to the resident when he received his other medications. Observation of Resident #1's medications on hand on 10/04/22 at 11:38am revealed there was no Gabapentin available for administration. Review of Resident #1's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Gabapentin 100mg, take 1 capsule by mouth three times a day with special instructions "*needs script*", scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Gabapentin 100mg was not documented as administered on 10/04/22 at 8:00am. Telephone interview with Resident #1's family member on 10/05/22 at 8:20am revealed the facility was responsible for ordering his medications. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/04/22 at 12:08pm revealed: -The pharmacy received the order for Gabapentin 100mg, three times a day on 09/24/22 but they required a physical prescription to fill that medication. -The pharmacy communicated the need for a physical prescription for Resident #1 on 09/24/22 and placed the comment on the eMAR	D 358		

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D 358	Continued From page 12 about Gabapentin needing a script. -The pharmacy had yet to dispense Gabapentin for Resident #1 because they were still waiting on a physical script. Interview with the MA on 10/04/22 at 11:40am revealed: -She was not aware that Resident #1 did not have any Gabapentin available for administration on 10/04/22. -It was the responsibility of the MA that gave the last dose of medication to re-order the medication. -Residents should have medications on hand and available for administration. -She did not notify Resident #1's primary care provider (PCP) that he missed this morning's dose of Gabapentin. Interview with the Special Care Coordinator (SCC) on 10/04/22 at 12:00pm revealed: -The facility was transitioning to a new pharmacy and was learning how to re-order medications online. -She believed the request to fill Resident #1's Gabapentin was sent to the pharmacy on 10/01/22. -She expected residents to have their medications available for administration, including Resident #1's Gabapentin. A second interview with the SCC on 10/05/22 at 3:00pm revealed:	D 358		

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D 358	Continued From page 13 -She received a hold order yesterday (10/04/22) from Resident #1's Mental Health Provider (MPH) for his Gabapentin until the medication was available for administration. -Resident #1's Gabapentin arrived at the facility on 10/05/22 and was re-started. -She was aware that it was her responsibility to get an order to hold a medication, per the facility's policy, until the medication was available. -Cart audits were to be conducted weekly, but she could not recall the last time Resident #1 had a cart audit completed. Interview with the Executive Director (ED) on 10/05/22 at 7:30am revealed she expected Resident #1's medications to be on hand and administered as ordered including his Gabapentin. Telephone interview with Resident #1's MHP on 10/05/22 at 2:40pm revealed: -She started Resident #1 on Gabapentin to help treat his pain. -The SCC was in communication with her about the need for a physical prescription which she sent yesterday to the pharmacy. -She expected Resident #1 to have all medications ordered available for administration, including his Gabapentin. Based on observations, interviews and record reviews, it was determined that Resident #1 was	D 358		

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D 358	Continued From page 14 not interviewable. 2. Review of Resident #6's current FL-2 dated 09/08/22 revealed: -Resident's diagnoses included dementia, rheumatoid arthritis, hypertension, and kidney disease. -There was an order for Trazadone 25mg three times a day (Trazadone is an antidepressant used to treat depression). Review of Resident #6's previous orders dated 07/13/22 revealed there was an order for Trazadone 25mg to be administered at 7:00am, 11:00am, and 5:00pm. Observation of the 8:00am medication pass on 10/04/22 revealed the medication aide (MA) prepared and administered six medications to Resident #6 at 9:08am from her multiple medication dose packet including Trazadone 50mg, ½ of a tablet. Review of Resident #6's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Trazadone 25mg to be administered three times a day, scheduled for administration at 7:00am, 11:00am, and 5:00pm. -Trazadone 25mg was documented as administered on 10/04/22 at 7:00am. Interview with the MA on 10/04/22 at 11:40am	D 358		

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D 358	Continued From page 15 revealed: -She normally administered Resident #6's Trazadone when she first started her morning medication pass at 7:30am. -She was delayed today in getting the resident her Trazadone because she was behind on getting on the medication cart. -There was period of one hour before and one hour after for medications to be administered and Resident #6 should have received her Trazadone between 6:00am and 8:00am because it was scheduled at 7:00am. Interview with the Special Care Coordinator (SCC) on 10/04/22 at 12:00pm revealed: -She was not aware that Resident #6 received her Trazadone after 9:00am until the MA informed her. -She called Resident #6's Mental Health Provider (MHP) to make her aware and the MHP ordered to hold the 11:00am dose because of the delay. -She expected medications to be administered during the ordered time, with the one hour before and one hour after timeframe. -Because the MA administered the medication over a hour late, it would have put the next dose of Trazadone too close to being administered putting the resident at risk for fall or over sedation. Interview with the Executive Director (ED) on 10/05/22 at 7:30am revealed she expected Resident #6's Trazadone to be administered	D 358		

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D 358	Continued From page 16 within the ordered timeframe. Telephone interview with Resident #6's MHP on 10/05/22 at 2:40pm revealed: -She expected Resident #6's medications to be administered as ordered including Trazadone. -Medications were to be administered up to an hour before or an hour after the scheduled time. -The SCC called and notified her yesterday that there was a late administration of Trazadone for Resident #6 and she ordered the 11:00am dose to be held. -Resident #6 was on Trazadone for a long time and missing a dose would not cause any harm to the resident. Based on observations, interviews and record reviews, it was determined that Resident #6 was not interviewable.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NACA 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment;	D 367		

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D 367	Continued From page 17 (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration (7) documentation of any omission of medications or treatments and the reason for omission, including, refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidence by: Based on interviews and record reviews, the facility failed to ensure the medication administration record (MAR) was complete and accurate for 1 of 5 residents sampled (#1) for a pain medication. The findings are: Review of the facility's Medication Administration Policy dated 09/21 revealed missed or refused medications are documented in the resident's medication administration record (MAR) and the provider, responsible party is notified, and it is documented. Review of Resident #1's current FL-2 dated 01/17/22 revealed diagnoses included vascular dementia, malignant neoplasm of the pancreas,	D 367		

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D 367	Continued From page 18 heart disease, and hypertensive chronic kidney disease. Review of Resident #1's physician orders dated 09/23/22 revealed there was an order for Gabapentin 100mg three times a day (Gabapentin is a medication used to treat nerve pain). Review of Resident #1's September 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Gabapentin 100mg, take 1 capsule by mouth three times a day with special instructions "*needs script*", scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Gabapentin 100mg was documented as administered on from 09/26/22 to 09/30/22 at 8:00am, 2:00pm, and 8:00pm. Review of Resident #1's October 2022 eMAR revealed: -There was an entry for Gabapentin 100mg, take 1 capsule by mouth three times a day with with special instructions "*needs script*", scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Gabapentin 100mg was documented as administered on from 10/01/22 to 10/03/22 at 8:00am, 2:00pm, and 8:00pm. Observation of Resident #1's medications on	D 367		

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D 367	Continued From page 19 hand on 10/04/22 at 11:38am revealed there was no Gabapentin available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/04/22 at 12:08pm revealed the pharmacy received the order for Gabapentin 100mg, three times a day on 09/24/22 but the never dispensed the medication because they were waiting for the facility to send a physical prescription. Interview with a medication aide (MA) on 10/04/22 at 11:40am revealed: -The MAs were responsible for documenting on the eMAR. -If a resident did not have a medication available for administration, the MAs should have documented the medication as 'not given' and added a comment with a reason why it wasn't administered. -She was not sure why Resident #1's Gabapentin was signed off for 24 doses unless the MAs just clicked off the medication without reading the order. Interview with the Special Care Coordinator (SCC) on 10/04/22 at 12:00pm revealed: -MAs were responsible for documenting appropriately on the eMAR. -If a medication was not available for administration, the MAs should document 'not given' with a reason. -She was not aware that MAs were documenting	D 367		

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D 367	Continued From page 20 that Resident #1's Gabapentin was being administered even though there was none available for administration. Interview with the Executive Director on 10/05/22 at 7:30am revealed it was the MAs responsibility to ensure that eMAR were complete and accurate.	D 367		

10A NCAC 13F .0703(c-4) Tuberculosis Test, Medical Examination and Immunizations

All current resident FL-2 forms will be reviewed by the Memory Care Manager or her designee to ensure they are complete and accurate. Any FL-2 forms missing information will be have new FL-2 forms completed by resident provider.

Complete by November 22, 2022

All new admission's or readmission's FL-2 forms will be reviewed by Memory Care Manager or her designee and all corrections requested and received prior to admission

Complete November 22, 2022

All FL-2 annual renewals will also be reviewed by Memory Care Manager or her designee and any corrections needed requested by provider within 24 hours of receiving.

Complete November 22, 2022

10A NCAC 13F .0904 (f)(2) Nutrition and Food Service Individual Feeding Assistance in Adult Care Homes (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

In-service on providing appropriate feeding assistance to enhance and maintain resident's dignity and respect to include ensuring we provide feeding assistance at eye level of resident and in an unhurried manner will be provided for all staff responsible for feeding residents.

Complete November 22, 2022

Executive Director or her designee will monitor three meals per week to ensure staff are providing appropriate feeding assistance.

Complete November 22, 2022

10A NCAC 13F .1004(a) Medication Administration

(a) An adult care home shall assure that the p reparation 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

Registered Nurse will provide an in-service to medication aides, Memory Care Manager and Lead Supervisor in charge reviewing how to conduct an appropriate cart audit, when to order medications when supply is low and how to get medications to the community in an emergency if medication is not able to be found in the medication cart. Training will also be provided on scanning medications to ensure we are providing them at the correct time.

Complete November 22, 2022

Memory Care Manager or her designee will ensure all weekly cart audits are completed and reviewed for medication refills. All medications in short supply will be ordered and inventoried by Memory Care Manager or her designee.

Complete November 22, 2022

Memory Care Manager or her designee will review multi-dose packaging to ensure medications are in appropriate bubbles and request changes needed from community pharmacy.

Complete November 22, 2022

Memory Care manager or her designee will perform medication aide observation during medication passes once weekly to ensure appropriate regulations and policies and procedures are being used during medication pass. Immediate training and coaching will be provided to staff if errors are found.

Complete November 22, 2022

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Registered Nurse will provide in-service to all medication aide staff regarding the appropriate required documentation for Medication Administration Record.

Complete November 22, 2022

Memory Care Manager or her designee will review MAR's for a sample of at least five residents weekly to ensure documentation accuracy.

Completed November 22, 2022