DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: HAL060158	MULTIPLE CONSTRUCTION A. BUILDING: B. WING	DATE SURVEY COMPLETED: 09/22/2022
NAME OF PROVIDER: The Charlotte Assisted Living	STREET ADDRESS, CITY, STATE, ZIP CODE: 9120 Willow Ridge Drive Charlotte, NC 28210		

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)	DATE COMPLETE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on September 20-22, 2022.		RECEIVED FROM SURVEY 11/30/22 DUE TO SYSTEM – DOOWN.	
D235	10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. (c) 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: This Rule is not met as evidenced by: D 235 Based on record review and staff interviews, the facility failed to ensure an annual FL2 was completed for 3 of 7 sampled residents (#1, #4, #6). The finding are: 1. Review of Resident #1's most recent FL2 dated 07/19/21 revealed diagnoses included history of gastrointestinal bleeding with anemia (low blood count) and forgetfulness. Review of Resident #1's resident register revealed an admission date of 07/16/21.	D235	1. **D 235: 10A NCAC 13F .0703**- It is the policy of this facility that residents shall have a medical examination annually entered on the FL 2, signed by the physician, and placed in the resident chart. 2. The Resident Care Director (RCD) ensured medical examinations recorded on a FL 2 completion for Resident #1, #4 and #6, ensured signature of the physician and filed the FL 2's in each appropriate resident chart. The Vice President of Clinical Development provided education to the RCD related to the requirement of annual FL 2's for each resident on admission and annually. Education completed on 10/26/2022 The RCD and/or designee will ensure annual FL 2 completion for each Compliance. 3. Any deficiencies shall be corrected immediately. RECEIVED DEC 1 6 2022 ADULT CARE LICENSURE SECTION RALEIGH	12/16/2022

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE: Julie Workman | TITLE: Executive Director | DATE: 12/13/22

STATE FORM – DHSR LIMITED USE STATEMENT OF DEFICIENCIES

Reviewed and Acknowledged on 01/17/2023. Sharon Dunton RN

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D235	Continued from Page 1 Review of Resident #1's record revealed there was not an updated FL2 completed or signed by the primary care provider (PCP) after 07/19/21. Refer to the interview with the Resident Care Director (RCD) on 09/22/22 at 4:02pm. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm. Attempted telephone interview with Resident #1's PCP on 09/21/22 at 11:47am was unsuccessful. 2. Review of Resident #4's most recent FL2 dated 06/08/21 revealed diagnoses included dementia, bipolar, hypertension, hyperlipidemia, gastroesophageal reflux disease, and atrial fibrillation. Review of Resident #4's resident register revealed an admission on 07/19/21. Review of Resident #4's record revealed there was not an updated FL2 completed or signed by the primary care provider (PCP) after 06/08/21. Refer to the interview with the RCD on 09/22/22 at 4:02pm. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm.			

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D235	Continued from Page 2 Attempted telephone interview with Resident #4's PCP on 09/22/22 at 1:45pm was unsuccessful. 3. Review of Resident #5's most recent FL2 dated 05/11/21 revealed diagnoses included hypertension, diabetes, coronary artery disease and mild cognitive impairment. Review of Resident #5's resident register revealed an admission on 05/18/21. Review of Resident #5's record revealed there was not an updated FL2 completed or signed by the primary care provider (PCP) after 05/11/21. Refer to the interview with the RCD on 09/22/22 at 4:02pm. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm. Attempted telephone interview with Resident #5's PCP on 09/22/22 at 1:45pm was unsuccessful. Interview with the RCD on 09/22/22 at 4:02pm revealed: -She was responsible for ensuring that all of the residents had up to date FL2s. -She started working at the facility five weeks ago and was not aware that some residents had FL2s that were out of date.			

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D235	Continued from page 3 -The facility had a paper tracking system for FL2 due dates, but it was inaccurate. -The facility had not finalized an audit system to ensure that FL2s were completed on time. Interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm revealed: -The RCD was responsible for ensuring that residents had FL2s completed on a yearly basis. -The electronic database that the facility used provided an alert when a resident's FL2 was due. -The RCD was trained on the electronic database shortly after being hired. -Since July 2022, she had several meetings with RCD and staff at the facility to improve compliance with documentation and expected all of the residents to have up to date FL2s.			
D276	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 observations, interviews and record reviews, the facility failed to implement	D276	1. **D276 NCAC 13F .0902**- All new orders will be transcribed to the Medication Administration Record and sent to the pharmacy. Updated FL2's will be sent to the pharmacy upon receipt and transcribed to the Medication Administration Record. 2. The RCD/RCC/Designee will ensure that all orders, and FL2's are accurately transcribed on the eMAR. And audit weekly 3. Medication Techs education on Transcribing orders. 4. Any deficiencies shall be corrected immediately.	12/09/2022

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE | TITLE | DATE3

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: HAL060158	MULTIPLE CONSTRUCTION A. BUILDING: B. WING	DATE SURVEY COMPLETED: 09/22/2022

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D276	Continued from page 4 physician's orders for 2 of 7 sampled residents (#3 and #5) related to a pain-relieving medication (#3), a steroid and nebulizer treatment (#5). The findings are: 1.Review of Resident #3's current FL2 dated 07/22/22 revealed: -Diagnoses included leg swelling and elevated blood pressure. -An order for acetaminophen 650mg extended release (ER) (a medication used for pain relief) three times daily. Review of Resident #3's July 2022 electronic medication administration record (eMAR) revealed: -An entry for acetaminophen 650mg ER scheduled for 1:00am, 8:00am and 7:00pm. -Acetaminophen 650mg ER was documented as administered at 1:00am, 8:00am and 7:00pm from 07/01/22 to 07/31/22. Review of Resident #3's August 2022 eMAR revealed: -An entry for acetaminophen 650mg ER scheduled for 1:00am, 8:00am and 7:00pm. -Acetaminophen 650mg ER was documented as administered at 1:00am, 8:00am and 7:00pm from 08/01/22 to 08/31/22.			

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D276	Continued from page 5 Review of Resident #3's September 2022 eMAR revealed: -An entry for acetaminophen 650mg ER scheduled for 1:00am, 8:00am and 7:00pm. -Acetaminophen 650mg ER was documented as administered at 1:00am, 8:00am and 7:00pm from 09/01/22 to 09/19/22. -Acetaminophen 650mg ER was documented as administered at 1:00am, 8:00am on 09/20/22. Review of Resident #3's medication on hand on 09/21/22 at 4:28pm revealed: -There was not any acetaminophen 650mg ER scheduled three times per day on the medication cart. -There was acetaminophen 650mg ER scheduled two times per day on the medication cart. Interview with Resident #3 on 09/22/22 at 10:40am revealed: -The medication aides (MA) gave her scheduled acetaminophen twice a day. -She was prescribed acetaminophen to help with the pain in her legs. -Her pain had been manageable on the twice a day scheduled acetaminophen but sometimes she had pain at night that required use of non-scheduled acetaminophen. Refer to the interview with a MA on 09/22/22 at 11:00am.			

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D276	Continued from page 6 Telephone interview with the Pharmacist from the facility's contracted pharmacy on 09/21/22 at 4:48pm revealed: -The pharmacy had an order for acetaminophen 650mg ER twice a day that was signed on 03/25/22. -The pharmacy did not have a copy of Resident #3's FL2 that was dated 07/22/22. -The facility typically sent medication orders to the pharmacy by an electronic escript, faxing printed medication orders or faxing a new FL2. -The facility added medications to their eMARs and the pharmacy was not able to view them. Interview with the Resident Care Coordinator (RCC) on 09/22/22 at 11:05am revealed: -She faxed signed physician orders to the pharmacy but did not fax annual FL2s to the pharmacy. -She did not remember if she was trained to fax FL2s to the pharmacy. Interview with the Resident Care Director (RCD) on 09/22/22 at 9:30am revealed: -When a resident came back from the hospital, the paperwork should have been given to her or put on her desk. -She did not always receive residents' paperwork. -When a resident had a new FL2 signed, she sent it to the pharmacy so the medications could be filled. -She was not aware Resident #3 had a new FL2 on			

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D276	Continued from page 7 07/22/22 and that is why it was never sent to the pharmacy. -She was not aware that Resident #3's order for acetaminophen 650mg ER changed from twice daily to three times daily on 07/22/22. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm. Attempted telephone interview with Resident #3's PCP on 09/21/22 at 11:47am was unsuccessful. 2. Review of Resident #5's current FL2 dated 05/11/21 revealed diagnoses included diabetes, hypertension, coronary artery disease and mild cognitive impairment. a. Review of signed physician's orders dated 08/03/22 revealed an order for ipratropium-albuterol 0.5-2.5mg/ 3ml (a medication used to treat wheezing and shortness of breath caused by breathing problems) inhalation four times daily. Review of Resident #5's August 2022 electronic medication administration record (eMAR) revealed there was not an entry for ipratropium-albuterol 0.5-2.5mg/ 3ml inhalation four times daily. Review of Resident #5's September 2022 eMAR revealed there was not an entry for ipratropium- albuterol 0.5-2.5mg/ 3ml inhalation four times daily.			

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D276	Continued from page 8 Observation of Resident #5's medications on the medication cart on 09/21/22 at 5:40pm revealed: -A box labeled ipratropium-albuterol 0.5-2.5mg with six silver packages inside. -One of the packages was open and had three vials remaining in the package. Interview with Resident #5 on 09/22/22 at 10:52am revealed the only breathing treatment that he had recently used was a twice a day inhaler that he had used for many years. Refer to the interview with a MA on 09/22/22 at 11:00am. Interview with the Resident Care Coordinator (RCC) on 09/22/22 at 12:59pm revealed: -She did not add the ipratropium-albuterol to the eMAR on the day she received the paperwork since the medication was not in the building. -She did not add medication to the eMAR until the facility received the medication in case there was a delay in delivery from the pharmacy. -She expected the MA to notify her when the ipratropium-albuterol was delivered, and she would have entered the medication on the eMAR remotely. -She could not remember if an MA contacted her to put ipratropium-albuterol on Resident #5's eMAR. Interview with the Resident Care Director (RCD) on 09/22/22 at 1:30pm revealed:			

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D276	Continued from page 9 -She was responsible to put new orders the resident's electronic Medication Administration Record (eMAR). -She had the capability to put new orders on the eMARs from home at any time. -If she was sick, the RCC was responsible to put new orders on the eMAR. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/22/22 at 1:13pm revealed: -The pharmacy received a signed physician's order for ipratropium-albuterol 0.5mg-2.5mg/ 3ml four times per day on 08/03/22. -A box with 180 mL of ipratropium-albuterol 0.5mg- 2.5mg, 60 doses, was dispensed on 08/03/22. -If Resident #5 did not receive the ipratropium- albuterol as ordered, he could see a delay in his symptoms improving and could be at risk for hospitalization due to shortness of breath. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm. b. Review of Resident #5's hospital discharge summary dated 09/08/22 revealed: -Discharge diagnosis was aspiration syndrome (condition in which foods, stomach contents, or fluids are breathed into the lungs through the windpipe). -An order for methylprednisolone 4mg (a medication that is used different inflammatory			

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D276	Continued from page 10 conditions and conditions that affect the lungs), five-day taper dose pack take as directed on package instructions. Review of Resident #5's September 2022 electronic medication administration record (eMAR) revealed there was not an entry for methylprednisolone 4mg, five-day taper dose pack. Observation of Resident #5's medications on the medication cart on 09/21/22 at 5:40pm revealed: -An opened package of methylprednisolone 4mg with seventeen tablets in the package and a dispense date of 09/08/22. -None of the tablets had been removed from the bubble pack medication card. Refer to the interview with a MA on 09/22/22 at 11:00am. Interview with the RCC on 09/22/22 at 12:59pm revealed: -She processed Resident #5's hospital discharge summary dated 09/08/22. -She did not add the methylprednisolone 4mg taper pack to the eMAR on the day she received the paperwork since the medication was not in the building. -She did not add medication to the eMAR until the facility received the medication in case there was a delay in delivery.			

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D276	Continued from page 11 -She expected the MA to notify her when the methylprednisolone was delivered, and she would have entered the medication on the eMAR remotely. -She could not remember if an MA contacted her to put methylprednisolone on Resident #5's eMAR. Interview with the RCD on 09/22/22 at 1:30pm revealed: -She was responsible to put new orders the resident's electronic Medication Administration Record (eMAR). -She had the capability to put new orders on the eMARs from home at any time. -If she was sick, the RCC was responsible to put new orders on the eMAR. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/22/22 at 1:13pm revealed: -The pharmacy received a physician's order for methylprednisolone 4mg taper pack to take as directed on package instructions on 09/08/22 and it was delivered to the facility on 09/08/22 at 9:23pm. -The medication had instructions for a five-day taper. -The first day Resident #5 should have received: two tablets in the morning, one tablet at lunch, one tablet at supper and two tablets before bed. -The second day Resident #5 should have received:			

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D276 Continued from page 12

one tablet in the morning, one tablet at lunch, one tablet at supper and two tablets before bed.
-The third day Resident #5 should have received:
one tablet three times per day.
-The fourth day Resident #5 should have received:
one tablet twice a day.
-The fifth day Resident #5 should have received:
one tablet once a day.
-Since Resident #5 did not receive the methylprednisolone 4mg taper pack it could have caused a longer recovery time, or his symptoms could have lasted longer than they would have on the medication.

Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm.

Attempted telephone interview with Resident #5's PCP on 09/22/22 at 1:45pm was unsuccessful.

Interview with a MA on 09/22/22 at 11:00am revealed:
-When the pharmacy delivered medication, she looked at the resident's name to make sure the medication was put on the correct medication cart.
-She was assigned to audit medication carts once every one to two months.
-During the audit she looked at medications on the medication cart and made sure they were on the eMAR.
-If there was a medication on the cart that was not on the eMAR she alerted the RCD.

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D276	Continued from page 13 Interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm revealed: -The FL2 had active orders and it should have been sent to the pharmacy every time a resident had a new one signed. -Medication should have been added to the eMAR by the RCC or RCD when the order came in the building. -The RCC and RCD were responsible for auditing to ensure physician's orders matched the orders on the eMAR and the medication dispensed by the pharmacy. -Audits were expected to occur weekly with a sample of residents.			
D344	10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	D344	1. **10A NCAC 13F .1002-Medication orders** RCD/RCC/Designee shall contact physician for clarification/verification of any orders for medications and treatments to ensure that all orders are dated and signed by the physician within 24 hours of admission/readmission to facility. 2. Medication Techs education Completion 12/9/22. 3. .RCD/RCC/Designee to perform weekly audits. Audits will continue for 3 months or longer until substantiating compliance is reached. 4. Any deficiencies shall be corrected immediately.	12/16/2022

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D344	Continued from page 14 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to clarify orders with the provider for 1 of 7 sampled residents, related to an order for a medication to treat epilepsy and a medication to treat an enlarged prostate (Resident #7). The findings are: Review of Resident #7's current FL2 dated 07/28/22 revealed diagnoses included epilepsy and urinary incontinence. a. Review of Resident #7's current FL2 dated 07/28/22 revealed there was an order for divalproex sodium ER (a medication used to treat epilepsy) 250 mg, one tablet daily. Review of Resident #7's signed physician orders dated 06/28/22 revealed there was an order for divalproex sodium ER 250mg, three tablets daily. Review of Resident #7's July 2022, August 2022, and September 2022 electronic Medication Administration Records (eMAR) revealed: -There was an entry for divalproex sodium ER 250mg, three tablets daily. -The divalproex sodium ER 250mg, three tablets daily entry was documented as administered daily at 8:30am. Telephone interview with the Pharmacist at the			

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The Charlotte Assisted Living	**9120 Willow Ridge Drive Charlotte, NC 28210**

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
D344	Continued from page 15 facility's contracted pharmacy on 09/22/22 at 1:15pm revealed: -The current order for Resident #7's divalproex sodium ER was ordered on 06/28/22. -The order was for Resident #7 to receive divalproex sodium ER 250mg, three tablets daily, at 8:30am. -They did not have the FL2 dated 07/28/22 on file. Interview with Resident #7 on 09/22/22 at 10:40am revealed he could not remember all his medications. Observation of medications on hand for Resident #7 on 09/22/22 at 11:49am revealed a multidose pack containing divalproex sodium ER 250mg, 3 tablets was available for administration. Refer to the interview with the Resident Care Coordinator (RCC) on 09/22/22 at 11:05am. Refer to the interview with the Resident Care Director (RCD) on 09/22/22 at 9:36am. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm. Attempted telephone interview with Resident #7's Primary Care Provider (PCP) on 09/21/22 at 11:47am was unsuccessful. b. Review of Resident #7's current FL2 dated 07/28/22 revealed there was an order for			

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D344	Continued from page 16 tamsulosin (a medication used to treat an enlarged prostate) 0.4mg, one tablet daily. Review of Resident #7's signed physician orders dated 06/28/22 revealed there was an order for tamsulosin 0.4mg, two capsules daily. Review of Resident #7's July 2022, August 2022, and September 2022 electronic Medication Administration Records (eMAR) revealed: -There was an entry for tamsulosin 0.4mg two capsules daily. -The tamsulosin 0.4mg, two capsules daily entry was documented as administered daily at 8:00pm. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/22/22 at 1:15pm revealed: -The current order for Resident #7's tamsulosin was ordered on 06/28/22. -The order was for Resident #7 to receive tamsulosin 0.4mg, two capsules daily at 8:00pm. -They did not have the FL2 dated 07/28/22 on file. Interview with Resident #7 on 09/22/22 at 10:40am revealed he could not remember all his medications. Observation of medications on hand for Resident #7 on 09/22/22 at 11:49am revealed a multidose pack containing tamsulosin 0.4mg, 2 tablets was available for administration.			

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D344 Continued from page 17

Refer to the interview with the RCC on 09/22/22 at 11:05am.

Refer to the interview with the RCD on 09/22/22 at 9:36am.

Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm.

Attempted telephone interview with Resident #7' Primary Care Provider (PCP) on 09/21/22 at 11:47am was unsuccessful.

Interview with the RCC on 09/22/22 at 11:05am revealed:
-She was unsure who wrote the medications on Resident #7's FL2 dated 07/28/22.
-She thought the number "3", for 3 tablets was mistakenly omitted from the divalproex sodium entry on the FL2.
-She thought the number "2", for 2 tablets was mistakenly omitted from the tamsulosin entry on the FL2.
-She faxed signed physician orders to the pharmacy but did not fax annual FL2s to the pharmacy.
-She did not remember if she was trained to fax FL2s to the pharmacy.

Interview with the RCD on 09/22/22 at 9:36am revealed:
-Resident FL2s were to be faxed to the pharmacy.

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D344	Continued from page 18 -If a medication order on a resident's FL2 was different than the resident's current medication order, the order should be clarified with the resident's Primary Care Provider (PCP). -It was the responsibility of the RCD and the RCC to clarify resident orders with the PCP. Interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm revealed: -The RCC and the RCD were responsible to compare new orders with previous orders and to get clarification from the PCP when orders did not match or were unclear. -All FL2s were to be faxed to the pharmacy as they contained active orders.			
D358	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 record reviews and interviews, the facility failed to administer medications as ordered for 3 of 7 sampled residents (#7, #3 and #5) related to a medication used to treat epilepsy and a medication used to treat enlarged prostates (#7),	D358	1. **10A NCAC 13F .1004-** Medications/Treatments will be administered as ordered by physician. 2. Medication Techs education Completion 12/9/22. 3. RCD/RCC/Designee to perform weekly audits. Audits will continue for 3 months or longer until substantiating compliance is reached 4. Any deficiencies shall be corrected immediately. 5. [illegible]	12/30/2022

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D358	Continued from page 19 a medication used to treat pain (#3), a medication used to treat wheezing and shortness of breath and a medication used to treat inflammation (#5). The findings are: 1. Review of Resident #7's current FL2 dated 07/28/22 revealed: -Diagnoses included epilepsy and urinary incontinence. -There was an order for divalproex sodium ER (a medication used to treat epilepsy) 250 mg, one tablet daily. -There was an order for tamsulosin (a medication used to treat an enlarged prostate) 0.4mg, one tablet daily. a. Review of Resident #7's July 2022, August 2022, and September 2022 electronic Medication Administration Records (eMAR) revealed: -There was an entry for divalproex sodium ER 250mg, three tablets daily. -The divalproex sodium ER 250mg, three tablets daily entry was documented as administered daily at 8:30am. Interview with Resident #7 on 09/22/22 at 10:40am revealed he could not remember the names of all his medications. Observation of medications on hand for Resident #7 on 09/22/22 at 11:49am revealed a multidose pack containing divalproex sodium ER 250mg,			

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D358	Continued from page 20 3 tablets was available for administration. Refer to the interview with the Resident Care Coordinator (RCC) on 09/22/22 at 11:05am. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm. Attempted telephone interview with Resident #7's Primary Care Provider (PCP) on 09/21/22 at 11:47am was unsuccessful. b. Review of Resident #7's July 2022, August 2022, and September 2022 eMAR revealed: -There was an entry for tamsulosin 0.4mg two capsules daily. -The tamsulosin 0.4mg, two capsules daily entry was documented as administered daily at 8:00pm. Interview with Resident #7 on 09/22/22 at 10:40am revealed he could not remember the names of all his medications. Observation of medications on hand for Resident #7 on 09/22/22 at 11:49am revealed a multidose pack containing tamsulosin 0.4mg, 2 tablets were available for administration. Refer to the interview with the RCC on 09/22/22 at 11:05am. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm.			

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D358	Continued from page 21 Attempted telephone interview with Resident #7's PCP on 09/21/22 at 11:47am was unsuccessful. 2. Review of Resident #3's current FL2 dated 07/22/22 revealed: -Diagnoses included elevated blood pressure and leg swelling. -An order for acetaminophen 650mg extended release (ER) (a medication used for pain relief) three times daily. Review of Resident #3's July electronic medication administration record (eMAR) revealed: -An entry for acetaminophen 650mg ER one tablet three times daily, scheduled at 1:00am, 8:00am and 7:00pm. -Acetaminophen 650mg ER was documented as administered three times daily from 07/01/22 to 07/31/22. Review of Resident #3's August eMAR revealed: -An entry for acetaminophen 650mg ER one tablet three times daily, scheduled at 1:00am, 8:00am and 7:00pm. -Acetaminophen 650mg ER was documented as administered three times daily from 08/01/22 to 08/31/22. Review of Resident #3's September eMAR revealed: -An entry for acetaminophen 650mg ER one tablet three times daily, scheduled at 1:00am, 8:00am and 7:00pm.			

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D358	Continued from page 22 -Acetaminophen 650mg ER was documented as administered three times daily from 09/01/22 to 09/19/22. Observation of Resident #3's medications on the medication cart on 09/21/22 at 4:28pm revealed a multidose package of medication that included acetaminophen 650mg ER with instructions to take 1 tablet twice daily. Interview with Resident #3 on 09/22/22 at 10:40am revealed: -She received scheduled acetaminophen for pain in both of her legs. -A medication aide (MA) gave her acetaminophen twice daily, in the morning and at night. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 09/21/22 at 4:48pm revealed: -The pharmacy did not have Resident #3's FL2 dated 07/22/22 with the order for acetaminophen 650mg ER one tablet three times daily. -The pharmacy did have an order for acetaminophen 650mg ER one tablet twice daily that was ordered by Resident #3's primary care provider (PCP) on 03/25/22. -On 09/14/22, acetaminophen 650mg ER was dispensed with a seven-day supply (14 tablets). -The facility edited their own eMARs and the pharmacy was not able to view or edit them.			

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D358	Continued from page 23 Interview with a MA on 09/22/22 at 11:23am revealed: -Resident #3 received scheduled acetaminophen twice daily. -Resident #3 received medications in multidose packing from the pharmacy and she had one acetaminophen tablet in the morning dose pack as well as one acetaminophen tablet in the evening dose pack. -She thought there was a glitch with the eMAR that showed acetaminophen scheduled three times per day since the pharmacy only sent acetaminophen twice daily for Resident #3. Interview with the Resident Care Director (RCD) on 09/22/22 at 9:30am revealed: -She was not aware Resident #3 had an FL2 dated 07/22/22. -She sent the FL2s to the pharmacy. -Since she was not aware of that FL2, the order for acetaminophen 650mg ER tablet three times daily was never sent to the pharmacy. -She was not aware that Resident #3's acetaminophen was changed from twice daily to three times daily on 07/22/22. Refer to the interview with a MA on 09/22/22 at 11:00am. Refer to the interview with the Resident Care Coordinator (RCC) on 09/22/22 at 11:05am.			

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D358	Continued from page 24 Refer to the interview with the RCD on 09/22/22 at 9:30am. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm. Attempted telephone interview with Resident #3's PCP on 09/21/22 at 11:47am was unsuccessful. 3. Review of Resident #5's current FL2 dated 05/11/21 revealed diagnoses included diabetes, coronary artery disease, history of a pacemaker and mild cognitive impairment. a. Review of Resident #5's signed physician orders dated 08/03/22 revealed an order for ipratropium- albuterol 0.5-2.5mg/ 3ml (a medication used to treat wheezing and shortness of breath caused by breathing problems) inhalation four times daily. Review of Resident #5's hospital discharge summary dated 09/08/22 revealed: -He had a discharge diagnosis of aspiration syndrome (a condition in which foods, stomach contents, or fluids are breathed into the lungs through the windpipe). -An order for ipratropium-albuterol 0.5- 2.5mcg/3 mL inhalation four times daily. Review of Resident #5's August 2022 electronic medication administration record (eMAR) revealed there was not an entry for ipratropium-albuterol 0.5-2.5mg/ 3ml inhalation four times per day.			

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D358	Continued from page 25 Review of Resident #5's September 2022 eMAR revealed there was not an entry for ipratropium- albuterol 0.5-2.5mg/ 3ml inhalation four times daily. Observation of Resident #5's medications on the medication cart on 09/21/22 at 5:40pm revealed: -A box labeled ipratropium-albuterol 0.5-2.5mg with six silver packages inside. -One of the silver packages was open and had three vials of medication remaining. Interview with Resident #5 on 09/22/22 at 10:52am revealed the only breathing treatment that he had recently used was a twice a day inhaler that he had used for many years. Interview with a MA on 09/22/22 at 11:00am revealed: -She had not given Resident #5 an ipratropium- albuterol treatment recently since it was an old medication from when he was hospitalized. -She was not aware that the ipratropium-albuterol was still on the medication cart. Interview with the Resident Care Coordinator (RCC) on 09/22/22 at 12:59pm revealed: -She processed Resident #5's hospital discharge summary dated 09/08/22. -She did not add the ipratropium-albuterol to the eMAR on the day she received the paperwork since the medication was not in the building.			

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D358	Continued from page 26 -She did not add medication to the eMAR until the facility received the medication in case there was a delay in delivery. -She expected the MA to notify her when the ipratropium-albuterol was delivered, and she would enter the medication on the eMAR remotely. -She could not remember if an MA contacted her to put ipratropium-albuterol on Resident #5's eMAR. Refer to the interview with the Resident Care Director (RCD) on 09/22/22 at 9:36am and 1:30pm. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/22/22 at 1:13pm revealed: -The pharmacy received a signed physician's order for ipratropium-albuterol 0.5mg-2.5mg/ 3ml four times daily on 08/03/22. -A box with 180 mL of ipratropium-albuterol 0.5mg- 2.5mg, 60 doses, was dispensed on 08/03/22. -If Resident #5 did not receive the ipratropium- albuterol as ordered, he could see a delay in his symptoms improving and could be a risk for hospitalization due to shortness of breath. Refer to the interview with a MA on 09/22/22 at 11:00am. Refer to the interview with the Vice President of			

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D358	Continued from page 27 Clinical Development on 09/22/22 at 4:13pm. b. Review of Resident #5's hospital discharge summary dated 09/08/22 revealed: -He was admitted for aspiration syndrome on 09/04/22. -An order for methylprednisolone 4mg (a medication used to treat inflammation), five-day taper dose pack. Review of Resident #5's September 2022 eMAR revealed there was not an entry for methylprednisolone 4mg, five-day taper dose pack. Observation of Resident #5's medications on the medication cart on 09/21/22 at 5:40pm revealed an opened package of methylprednisolone 4mg with seventeen tablets in the package and a dispense date of 09/08/22. Interview with an MA on 09/22/22 at 11:00am revealed: -She was not aware the methylprednisolone 4mg was on the medication cart for Resident #5 and had not given him any of that medication. -She was assigned to do medication cart audits once every one to two months and made sure that all the medications on the cart were also on the eMAR. -If a medication was on the medication cart and not the eMAR she was supposed to notify the RCD. -The contracted pharmacy delivered medications			

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D358	Continued from page 28 at 8:30pm and she only checked the resident's name before putting the medication on the medication cart. -She did not compare the medication to the eMAR before putting it on the medication cart. Interview with the RCC on 09/22/22 at 12:59pm revealed: -She processed Resident #5's hospital discharge summary dated 09/08/22. -She did not add the methylprednisolone 4mg to the eMAR on the day she received the paperwork since the medication was not in the building. -She did not add medication to the eMAR until the facility received the medication in case there was a delay in delivery. -She expected the MA to notify her when the methylprednisolone 4mg was delivered and she would enter the medication on the eMAR remotely. -She could not remember if an MA contacted her to put methylprednisolone on Resident #5's eMAR. Refer to the interview with the RCD on 09/22/22 at 9:36am and 1:30pm. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/22/22 at 1:13pm revealed: -The pharmacy received a physician's order for methylprednisolone 4mg taper pack on 09/08/22 and it was delivered on 09/08/22 at 9:23pm.			

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D358 Continued from page 29

-The medication was to be given over a five-day taper.
-The first day Resident #5 should have received:
two tablets in the morning, one tablet at lunch, one tablet at supper and two tablets before bed.
-The second day Resident #5 should have received: one tablet in the morning, one tablet at lunch, one tablet at supper and two tablets before bed.
-The third day Resident #5 should have received:
one tablet three times per day.
-The fourth day Resident #5 should have received:
one tablet twice a day.
-The fifth day Resident #5 should have received:
one tablet once a day.
-Since Resident #5 did not receive the methylprednisolone 4mg taper pack it could have caused a longer recovery time, or his symptoms could have lasted longer than they would have on the medication.

Refer to the interview with a MA on 09/22/22 at 11:00am.

Refer to the interview with the RCC on 09/22/22 at 11:05am.

Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm.

Attempted telephone interview with Resident #5's PCP on 09/22/22 at 1:45pm was unsuccessful.

Interview with a MA on 09/22/22 at 11:00am

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D358	Continued from page 30 revealed: -She was assigned to do medication cart audits once every one to two months and made sure that all the medications on the cart were also on the eMAR. -If a medication was on the medication cart and not the eMAR she was supposed to notify the RCD. -The contracted pharmacy delivered medications at 8:30pm and she only checked the resident's name before putting the medication on the medication cart. -She did not compare the medication to the eMAR before putting it on the medication cart. Interview with the RCC on 09/22/22 at 11:05am revealed: -She faxed signed physician orders to the pharmacy but did not fax annual FL2s to the pharmacy. -She did not remember if she was trained to fax FL2s to the pharmacy. -She was unsure who wrote the medications on Resident #7's FL2 dated 07/28/22. -She thought the number "3", for 3 tablets was mistakenly omitted from the divalproex sodium entry on the FL2. -She thought the number "2", for 2 tablets was mistakenly omitted from the tamsulosin entry on the FL2. Interview with the RCD on 09/22/22 at 9:36am and 1:30pm revealed:			

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D358	Continued from page 31 -She was responsible to put new orders the resident's eMAR. -She had the capability to put new orders on the eMARs from home at any time. -The RCC was responsible to put new orders on the eMAR in her absence. -Resident FL2s were to be faxed to the pharmacy. Interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm revealed: -The FL2 should have been sent to the pharmacy to communicate new medication orders. -She expected a medication to be entered on the eMAR when the medication order came in the building. -MAs should look at the medication delivered by the pharmacy to ensure it is on the eMAR before it is put on the medication cart. -If a medication is on the medication cart and not on the eMAR, the medication should be removed from the cart. -MAs should notify the RCD if a medication is on the medication cart and not on the eMAR. -The RCC and RCD were responsible for to auditing medications on the medication cart and compare them to the physician's orders as well as the eMAR. -The medication audit was expected to occur once a week with a sample of residents.			

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The Charlotte Assisted Living	**9120 Willow Ridge Drive Charlotte, NC 28210**

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)	DATE COMPLETE
D375	Continued from page 32 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self- administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 3 of 7 sampled residents (#2, #5, and #7) had a physician's order to self-administer an antifungal cream (#2), a nasal spray (#5), an antifungal shampoo, an antifungal cream, and an antibacterial ointment (#7). The findings are: 1. Review of Resident #7's current FL2 dated 07/28/22 revealed diagnoses included encephalopathy (a brain disease), stroke with left spastic hemiparesis (weakness of the left side of the body), and memory loss. a. Review of Resident #7's current FL2 dated 07/28/22 revealed:	D375	1. **10A NCAC 13F .1005 Self Administration** Room Sweeps completed Explanation provided to resident. 2. Orders will be obtained from providers for self- administration of medication. Self-administration Assessment will be completed as well. 3. Education provided to staff by RCD/RCC regarding room sweeps and self-administration orders. 4. Room sweeps audits will be completed weekly for 4 weeks and then monthly for 3 months or longer until sustaining compliance is met.	12/16/2022

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D375	Continued from page 33 -There was an order for ketoconazole 2% shampoo (an antifungal shampoo) twice weekly. -There was no order for self-administration of medications. Observation of Resident #7's bathroom on 09/22/22 at 11:45am revealed there was a bottle of ketoconazole shampoo on the floor of shower. Observation of Resident #7's bathroom on 09/22/22 at 11:45am revealed there was a bottle of ketoconazole shampoo on the floor of the shower. Review of Resident #7's July 2022, August 2022, and September 2022 electronic Medication Administration Records (eMAR) revealed no entries for ketoconazole shampoo. Review of Resident #7's July 2022, August 2022, and September 2022 electronic Treatment Administration Record (eTAR) revealed: -There was an entry for ketoconazole 2% shampoo to be applied twice weekly. -The entry was documented as administered twice weekly. Interview with Resident #7 on 09/22/22 at 10:40am revealed: -He could not remember all of his medications anymore. -He used the shampoo each time he got his shower and they kept it in the shower, so it is easy for the staff to get.			

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D375	Continued from page 34 Interview with a MA on 09/22/22 at 11:45am revealed: -Resident #7's ketoconazole shampoo was not kept in the medication cart. -The shampoo was kept in Resident #7's bathroom, so the personal care aides (PCA) had access to it when they showered the resident. Refer to the interview with the Resident Care Director (RCD) on 09/22/22 at 12:00pm. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm. Attempted telephone interview with Resident #7's Primary Care Provider on 09/21/22 at 11:47am was unsuccessful. b. Review of Resident #7's current FL2 dated 07/28/22 revealed: -There was no order for butenafine hydrochloride 1% antifungal cream. -There was no order for self-administration of medications. Observation of Resident #7's bathroom on 09/22/22 at 11:45am revealed there was a tube of butenafine hydrochloride 1% antifungal cream on the counter near the sink. Review of Resident #7's July 2022, August 2022, and September 2022 electronic Medication Administration Records (eMAR) revealed there			

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D375	Continued from page 35 was no entry for butenafine hydrochloride antifungal cream. Review of Resident #7's July 2022, August 2022, and September 2022 electronic Treatment Administration Record (eTAR) revealed there was no entry for butenafine hydrochloride antifungal cream. Interview with a MA on 09/22/22 at 11:45am revealed she was not aware Resident #7 had antifungal cream in his room. Refer to the interview with the RCD on 09/22/22 at 12:00pm. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm. Attempted telephone interview with Resident #7's Primary Care Provider on 09/21/22 at 11:47am was unsuccessful. c. Review of Resident #7's current FL2 dated 07/28/22 revealed: -There was no order for Neosporin antibacterial ointment. -There was no order for self-administration of medications. Observation of Resident #7's bathroom on 09/22/22 at 11:45am revealed there was a tube of Neosporin antibacterial ointment on the counter			

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D375	Continued from page 36 near the sink. Review of Resident #7's July 2022, August 2022 and September 2022 electronic Medication Administration Records (eMAR) revealed no entry for Neosporin antibacterial ointment. Review of Resident #7's July 2022, August 2022, and September 2022 electronic Treatment Administration Record (eTAR) revealed there was no entry for the Neosporin antibacterial ointment. Interview with a MA on 09/22/22 at 11:45am revealed she was not aware Resident #7 had Neosporin antibacterial ointment in his room. Refer to the interview with the RCD on 09/22/22 at 12:00pm. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm. Attempted telephone interview with Resident #7's PCP on 09/21/22 at 11:47am was unsuccessful. 2. Review of Resident #2's current FL2 dated 04/08/22 revealed: -Diagnoses included multiple sclerosis, diabetes, osteoporosis, hypertension, neurogenic bowel and bladder and post traumatic seizure. -There was an order for miconazole nitrate 2% topical spray powder, an antifungal spray, as needed.			

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D375	Continued from page 37 -There was no order for self-administration of medications. Observation of Resident #2's bathroom on 09/22/22 at 6:00pm revealed: -There was a bottle of miconazole nitrate 2% topical spray powder on a shelf in Resident #2's bathroom. Review of Resident #2's July 2022, August 2022 and September 2022 electronic Treatment Administration Records (eTAR) revealed no entries for miconazole nitrate 2% topical spray powder. Interview with the resident on 09/21/22 at 6:05pm revealed the staff put the medication on him if he needed it but he had not used it in quite some time. Interview with the PCA (personal care assistant) on 09/21/22 at 6:05pm revealed: -She was not aware the medication could not be kept in the bathroom. -Resident #2 only used the medication when he had a rash which was not often. Attempted interview with Resident #2's PCP on 09/22/22 at 12:21pm was unsuccessful. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm.			

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D375	Continued from page 38 3. Review of Resident #5's current FL2 dated 05/11/21 revealed diagnoses included diabetes, mild cognitive impairment, and hypertension. Review of Resident #5's signed Physician's Order Sheet dated 07/19/22 revealed: -There was an order for fluticasone propionate 50mcg (a medication for used to relieve allergic and non-allergic nasal symptoms) 1 spray each nostril as needed per day for allergy symptoms. -There was no order to self-administer fluticasone propionate. Interview with Resident #5 on 09/20/22 at 3:13pm revealed: -He was not allowed to keep medication in his room and had to request all medications from the medication aide (MA). -He did not realize that he had a bottle of fluticasone propionate on his bedside table. Review of Resident #5's July 2022 electronic medication administration record (eMAR) revealed: -Fluticasone propionate was scheduled as needed once per day. -There was no entry on the eMAR indicating the fluticasone propionate was self-administered. Review of Resident #5's August 2022 electronic medication administration record (eMAR) revealed: -Fluticasone propionate was scheduled as needed			

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D375	Continued from page 39 once per day. -There was no entry on the eMAR indicating the fluticasone propionate was self-administered. Review of Resident #5's September 2022 electronic medication administration record (eMAR) revealed: -Fluticasone propionate was scheduled as needed once per day. -There was no entry on the eMAR indicating the fluticasone propionate was self-administered. Interview with a MA on 09/21/22 at 5:55pm revealed: -Resident #5 had not requested fluticasone propionate recently and had some on the medication cart. -She was not aware he had the medication in his room. Interview with the RCD on 09/20/22 at 3:45 pm revealed: -She was not aware Resident #5 had a bottle of fluticasone propionate on his bedside table. -His family member must have brought it in for him. Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm. Attempted telephone interview with Resident #5's PCP was unsuccessful.			

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D375 Continued from page 40

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	Interview with the RCD on 09/22/22 at 12:00pm revealed: -She was not aware Resident #7 had antifungal shampoo, antifungal cream and antibacterial ointment in his room. -She thought Resident #7 may have brought them from home. -A self-administration assessment and physician's order was required if a resident wanted to keep a medication in his or her room. Interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm revealed: -If a resident had medication in their room she expected the resident to have an order from the physician to allow self-administration and an assessment of the resident to determine competency for self-administration of medication. -The Administrator stated PCAs, MAs, the RCC and the RCD were checking resident's rooms for medications. -She was not sure how often resident's rooms were being checked for medication. -She was not aware that residents without a medication self-administration order and assessment had medication in their rooms.			
D433	10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made			

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D433	Continued from page 41 available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a	D433	1. **10A NCAC 13F .1201 -**Resident records/Charts including orders, provider notes were transferred to physical chart. 2. All providers/and third parties shall provide visit notes prior to their next visit in facility. 3. RCD/RCC/Designee will perform weekly audits to ensure up to date information is in the physical chart. 4. Any deficiencies shall be corrected immediately. 5. Completion date 12/16/22	12/16/2022

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D433	Continued from page 42 resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to maintain resident records in an orderly manner and readily available for review for 1 of 7 sampled residents (#5). Review of Resident #5's current FL2 dated 05/11/21 revealed diagnoses included coronary heart disease, status post pacemaker placement, diabetes and mild cognitive impairment. Review of the binder that held Resident #5's information on 09/20/22 at 12:42pm revealed: -Documents related to a visit on 08/25/22 for a bronchoscopy. -No other documents were in Resident #5's section of the binder. Review of Resident #5's record from 09/20/22 to 09/22/22 revealed: -On 08/25/22, Resident #5 had a bronchoscopy and documented recommendations included await bronchoalveolar lavage (involves insertion of a tube to visualize the airways and wash the lungs), biopsy, culture, and cytology results. -There were no test results related to Resident #5's bronchoscopy on 08/25/22 in his record.			

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D433	Continued from page 43 -On 09/08/22, it was documented on Resident #5's hospital discharge summary that he had an appointment with an Ear, Nose and Throat (ENT) doctor on 09/13/22. -There was no ENT note in Resident #5's record. -On 09/08/22, it was documented on Resident #5's hospital discharge summary that he had an appointment with his Primary Care Provider (PCP) on 09/16/22. -There were no PCP notes in Resident #5's record. Review of the information request sheet for Resident #5 on 09/21/22 revealed: -Resident #5's physician's notes from the last three months were requested on 09/20/22. -"Please request Primary Care Provider notes provider July-current" was written at the bottom of the sheet. Telephone interview with Resident #5's family member on 09/22/22 at 11:49am revealed: -Resident #5 did not use the facility contracted provider and she took him to all his medical appointments. -If any medication changes were made at Resident #5's appointment then she provided the paperwork to the Resident Care Coordinator (RCC) or the Resident Care Director (RCD). -She recalled giving the RCC paperwork on 09/16/22 from a physician's appointment. Interview with the RCD on 09/21/22 at 12:16pm revealed:			

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D433 Continued from page 44

-Resident #5 did not use the facility's contracted physician and his family member took him to all his appointments.
-She requested Resident #5's family member give the facility a copy of his physician's notes and orders but that did not always happen.

Refer to the interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm.

Interview with the Vice President of Clinical Development on 09/22/22 at 4:13pm revealed:
-The facility should have the physician's visit note with in ~~twenty-four hours of the resident seeing the~~ provider.
-The paperwork can be provided by family, emailed or efaxed to the facility.
-The RCD was responsible for ensuring the documents from all physician's visits were in the facility.
-The RCD should upload the documents to the facility's database and keep a paper copy in a file.
-She expected the documents to be uploaded to the database within one week of receiving them.

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