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CHARTER SENIOR LIVING OF CHARLOTTE	3610 RANDOLPH ROAD CHARLOTTE, NC 28211

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County DSS conducted an annual and follow up survey from 03/14/23 through 03/17/23.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, 1 of 4 sampled medication aides (MA) (Staff A) did not pass the written medication aide examination within 60 days of hire as an MA. The findings are: Review of Staff A's personnel record revealed: - Staff A was hired as a MA on 12/09/22. - Staff A completed the 15-hour medication aide	D 125	1.Staff "A" was pulled from the medication cart position immediately upon identification of missing north carolina medication technician certification. Staff "A" is now a caregiver until the proper certification has been received. 2.All staff medication certification was audited to ensure that they met the required state qualifications. No additional issues were identified. 3. Going forward, a checklist has been created and will be utilized on hire to ensure all of the requirements are met prior to the Med tech working the floor. 4.The ED or designee will ensure that the checklist and qualifications are maintained. All Medication aide records will be audited on hire, monthly x3 months and then quarterly to ensure files are up to date. Completion date 5/1/23.	

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

K - Wanke | Interim Executive Director | 4/27/23

Reviewed and acknowleged 05/16/23
Brianna Jameson RD, LDN

additional information added 05/16/23

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D 125	Continued From page 1	D 125		

training class on 11/10/22 and had a medication clinical skills validation completed on 12/09/22.
- There was no documentation Staff A successfully passed the written medication aide examination within 60 days of validation.

Observation on 03/14/23 at 9:15am revealed Staff A was administering medications to the residents.

Review of a resident's electronic medication administration records (eMAR) revealed Staff A administered medication on four days in February 2023 and five days in March 2023.

Interview with Staff A on 03/17/23 at 10:15am revealed:
- She began working in the facility in early September 2022 and started passing medication near the end of December 2022.
- She recalled having a medication clinical skills validation completed upon hire as a MA, and also had the 15-hour MA training class as well as diabetic training.
- She was scheduled to take the MA examination in January 2023, but she unable to take the exam and had to reschedule it.
- She notified the Health and Wellness Director (HWD) upon return to the facility that she was not able to take the MA test as scheduled.
- She had not told the Administrator or anyone else that she was unable to take the MA test.
- She was unaware that MAs were required to pass the MA examination within 60 days of becoming a MA.

Interview with Assistant Administrator on 03/16/23 at 12:00pm revealed:
-The facility did not have a current Business Office Manager (BOM) so she took over that

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D 125	Continued From page 2 positions responsibilities starting 03/01/23. -Staff A told her that she was scheduled to take the MA examination in January 2023 but was unable to take the examination because she did not have her social security card. Telephone interview with the Regional Registered Nurse (RN) on 03/17/23 at 1:04pm revealed: -The BOM should have audited Staff A's personnel file based on the due dates of the MA requirements. -It should have been identified that Staff A had not taken her MA examination within the 60-day period prior to March 2023. Interview with Administrator on 03/17/23 at 10:45am revealed: - Staff A began working in the facility in early September 2022. - The current Assistant Administrator was responsible for tracking staff qualifications. -Staff A was scheduled to take the MA test in January 2023 but she did not take the test. - Staff A told her that she notified the former HWD that she was unable to take the examination in January 2023. - At the time Staff A was scheduled to take the MA examination and did not do so, there was no HWD or BOM working in the facility. - She would have been the person Staff A would have reported that she was unable to take the MA examination, and Staff A had not notified her of this. -She expected staff to notify her immediately if the staff was unable to take the MA test, receive any required training, or unable to attend schedule training. Refer to tag D 358, 10A NCAC 13F .1004(a) Medication Administration	D 125		

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D 125	Continued From page 3 The facility failed to ensure one staff, who worked as a MA and administered medications to residents completed the medication aide examination within 60 days from hire resulting in medication errors. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/16/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 01, 2023.	D 125		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 2 of 5 sampled residents had an accurate care plan that was signed by a provider within 15 days of the residents' being assessed (#4 and #5).	D 263	1.Resident 4, 5's current Care plan was sent to be reviewed and signed by the Primary physician. 2. an audit was completed on all residents to assure that a care plan review and signature was completed by the Primary Physician. All missing reviews were sent for review and completion. 3. Inservice training was completed for all nursing staff related to assuring resident care plans are sent for review to the Primary care physician following admission and completed and returned within 15 days of assessment. 4. The ED, HWD or designee will audit all resident admissions weekly for one month, then monthly to assure compliance going forward. Date of compliance 5/12/23.	

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D 263	Continued From page 4 The findings are: 1. Review of Resident #4's current FL2 dated 01/17/23 revealed: -Diagnoses included Parkinson's disease and dementia. -Resident #4's recommended level of care was the Special Care Unit (SCU). -He was intermittently disoriented, semi-ambulatory and required assistance with bathing as well as dressing. Review of Resident #4's resident register revealed an admission date of 02/03/23. Review of Resident #4's Care Plan dated 02/06/23 revealed: -Resident #4 required limited assistance with bathing, dressing and tolieting. -The care plan did not document Resident #4's current diet order, which had been changed since the care plan was originally completed on 02/06/23. -Resident #4's physician had not signed the care plan. Interview with the Administrator on 03/14/23 at 2:30pm revealed: -She was not aware Resident #4's care plan that was completed 02/06/23 was not signed by his physician. -When she looked in Resident #4's file in the online system, she could see that the former HWD, who left in mid-February, had completed the care plan and that the Regional Registered Nurse (RN) had noted that it was not signed by his physician. Refer to telephone interview with the SCU	D 263		

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D 263	Continued From page 5 Coordinator (SCC) on 03/17/23 at 8:57am. Refer to interview with the facility's contracted Primary Care Provider (PCP) on 03/17/23 at 2:05pm. Refer to interview with the Administrator on 03/14/23 at 2:30pm. 2. Review of Resident #5's current FL2 dated 03/17/22 revealed: -Diagnoses included Alzheimer's Disease, dementia, and progressive aphasia (loss of ability to understand or express speech). -Resident #5's recommended level of care was the SCU. Review of Resident #5's resident register revealed an admission date of 04/01/22. Review of Resident #5's Care Plan dated 04/01/22 revealed: -The resident required extensive assistance with dressing and limited assistance with showers and personal hygiene tasks. -The care plan was dated 04/01/22 and was signed by the HWD and Resident #5's family member on 04/12/22. -Resident #5's PCP signed the care plan on 06/14/22. Interview with a MA on 03/17/23 at 11:05am revealed Resident #5 required assistance with showers, dressing, and transfers. Refer to the telephone interview with the SCC on 03/17/23 at 8:57am. Refer to the telephone interview with the facility's contracted PCP on 03/17/23 at 2:05pm.	D 263		

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D 263	Continued From page 6 Refer to the interview with the Administrator on 03/14/23 at 2:30pm. Telephone interview with the SCC on 03/17/23 at 8:57am revealed: -The HWD or licensed practical nurse (LPN) were responsible for assessing residents, filling out the care plan and contacting the provider to sign the care plan. -She was told there was a spreadsheet that was used to help ensure care plans were completed and signed within the required time frame, but she was not sure who managed the spreadsheet. -She knew care plans had to be signed by the provider within 15 days of the completed assessment. -She was not aware that two residents, who resided in the SCU, did not have their care plans signed by a provider within the required time frame. Telephone interview with the facility's contracted PCP on 03/17/23 at 2:05pm revealed: -Facility staff placed resident care plans that needed signed in her folder. -She signed the care plans when she was at the facility and placed them back in the folder. Interview with Administrator on 03/14/23 at 2:30pm revealed: -Care plans were supposed to be completed during the initial assessment for new residents and then annually or with significant changes in condition. -Once the care plan was completed at the initial assessment, the document should be faxed or emailed to their primary physician for review and to be signed. -The facility had been without a HWD since	D 263		

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D 263	Continued From page 7 mid-February 2023. -While the HWD position was vacant, the regional staff virtually assisted with reviewing care plans and notified her when they observed documents that still needed signatures.	D 263		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 2 of 5 sampled residents (#2 and #5) related to notifying the physician a medication was not given for weight gain greater than 3 pounds (#2), and for finger stick blood sugar (FSBS) greater than 350 (#5). The findings are: 1. Review of Resident #2's current FL2 dated 03/17/2022 revealed diagnoses included diabetes mellitus, hypertension, congestive heart failure (CHF), chronic kidney disease, and lymphedema. Review of Resident #2's record revealed there was no physician order for metolazone 2.5mg, 1 tablet daily as needed (prn) for weight gain over 3 pounds. Review of the January 2023 electronic medication administration record (eMAR) revealed: -There was not an entry for metolazone 2.5mg, 1 tablet daily prn for weight gain over 3 pounds.	D 273	1.Resident #2 AND #5'S notification completed for current health status review with Primary Physician. Parameters added to MAR for Dr notification for BS greater than 350 for Resident #5. Weight reviewed for Resident #2. Weight is currently stable, and MAR is corrected related to medication and parameters and weight gain and when to give the medication. 2. All resident orders were audited chart to MAR to cart to ensure that orders are correct, and parameters are in place if indicate, and physician notified if needed. Inservice training was completed for all nursing staff related to following physician orders and proper notification with change of condition, along with protocol for processing physician orders. ED, HWD or designee will audit and monitor the orders, MARS, and assure proper Physician notification on admission and ongoing. Audits will be performed weekly x2 months then monthly going forward. Compliance date 5/12/2023.	

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D 273	Continued From page 8 -There was documentation on 01/16/23 he weighed 238 pounds, a gain of 6 pounds from the previous day. -There was documentation on 01/25/23 he weighed 231.8 pounds, a gain of 5.2 pounds from the previous day. -There was documentation on 01/29/23 he weighed 225.2 pounds, a gain of 5.4 pounds from the previous day. Review of the February 2023 eMAR revealed: -There was not an entry for metolazone 2.5mg, 1 tablet daily prn for weight gain over 3 pounds. -There was documentation on 02/06/23 he weighed 235 pounds, a gain of 4.4 pounds from the previous day. -There was documentation on 02/08/23 he weighed 245.4 pounds, a gain of 19.8 pounds from the previous day. -There was documentation on 02/11/23 he weighed 229 pounds, a gain of 6 pounds from the previous day. Review of the March 2023 eMAR revealed: -There was not an entry for metolazone 2.5mg, 1 tablet daily prn for weight gain over 3 pounds. -There was documentation on 03/08/23 he weighed 227.8 pounds, a gain of 4.2 pounds from the previous day. -There was documentation on 03/12/23 he weighed 232.4 pounds, a gain of 6.6 pounds from the previous day. Observation of medications on hand on 03/15/23 at 10:26am revealed: -There was a bubble pack for metolazone 2.5mg, 1 tablet daily prn for weight gain over 3 pounds. -Twenty-five of thirty tablets remained on the card.	D 273		

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D 273	Continued From page 9 Interview with a facility Licensed Practical Nurse (LPN) on 03/16/23 at 1:31pm revealed: -She did not call the physician for a weight gain over 3 pounds daily. -She did not know there was an order for metolazone 2.5mg prn because it was not on the eMARs. -She could not find an order for metolazone 2.5mg prn. -Resident #2 never had a weight gain of 19.8 pounds as it had to be entered on the eMAR wrong. Interview with a medication aide (MA) on 03/16/23 at 4:52pm revealed: -She did not know why metolazone 2.5mg prn was not on the eMAR and said it was probably discontinued. -She never gave metolazone 2.5mg prn to Resident #2. -She never called the physician for a weight gain over 3 pounds. -Resident #2 never had a weight gain of 19.8 pounds and if he did she would have made the LPN aware. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/16/23 at 9:40am revealed: -Metolazone 2.5mg 1 tablet by mouth everyday prn for weight gain over 3 pounds was still an active order. -Resident #2's metolazone 2.5mg prn was an e-script that was sent to the pharmacy on 11/22/22. -Resident #2's metolazone 2.5mg prn was last dispensed on 11/22/22 for 30 tablets. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 03/17/23 at	D 273		

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D 273	Continued From page 10 12:06pm revealed: -Resident #2 had an active order to give metolazone 2.5mg 1 tab by mouth everyday prn for weight gain over 3 pounds. -He expected the facility to follow the parameters ordered by the physician and if there were errors, the physician should have been made aware. Telephone interview with the Regional Registered Nurse (RN) on 03/17/23 at 1:04pm revealed: -She and the other Regional RN remotely audited the eMARs on a weekly basis and looked at the orders that were uploaded in the facility's electronic record system. -The clinical staff were expected to audit the charts. Refer to interview with the Administrator on 03/17/23 at 3:13pm. Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 03/16/23 at 10:49am was unsuccessful. Attempted telephone interview with Resident #2's Nephrologist on 03/17/23 at 10:44am was unsuccessful. 2. Review of Resident #5's current FL2 dated 03/17/22 revealed diagnoses included Alzheimer's Disease, dementia, and progressive aphasia (loss of ability to understand or express speech). Review of Resident #5's PCP orders dated 12/20/22 revealed there was an order to check Resident #5's FSBS twice daily and to notify the PCP if the reading was greater than 350 or less than 70.	D 273		

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D 273	Continued From page 11 Review of Resident #5's January 2023 eMAR revealed: -There were three instances his FSBS was greater than 350. -On 01/18/23 at 3:57pm his FSBS was 486. -On 01/29/23 at 8:23am his FSBS was 444. -On 01/31/23 at 3:42pm his FSBS was 447. -There was no documentation Resident #5's PCP was notified of the blood sugar readings greater than 350. Review of Resident #5's February 2023 eMAR revealed: -There were two instances his FSBS was greater than 350. -On 02/11/23 at 4:06pm his FSBS was 367. -On 02/24/23 at 4:14pm his FSBS was 366. -There was no documentation Resident #5's PCP was notified of the blood sugar readings greater than 350. Interview with a MA on 03/16/23 at 12:55pm revealed: -The MAs were responsible for notifying the PCP when a FSBS was outside of parameters. -The MAs were responsible for documenting the PCP notification in the eMAR and completing a paper report that was to be placed in the resident's medical record. Interview with Resident #5's PCP on 03/17/23 at 2:06pm revealed: -She expected the MAs to notify her when Resident #5's FSBS readings were outside of the ordered parameters. -She reviewed Resident #5's FSBS results in the eMAR when she was at the facility because often staff did not notify her when they were outside of the ordered parameters.	D 273		

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D 273	Continued From page 12 Interview with the Administrator on 03/17/23 at 3:13pm revealed the MAs were responsible for notifying the resident's PCP when FSBS readings were outside of the ordered parameters. Interview with the Administrator on 03/17/23 at 3:13pm revealed: -The HWD was responsible for the auditing resident records and she thought the Regional RN was doing the auditing since the HWD left in December 2022. -She was not sure of everything that was included in the auditing process.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews and interviews, the facility failed to implement physician's orders for 2 of 5 sampled residents related to an order for a nectar thick liquid (#4) and an order for a medication used for sleeplessness (#1). The findings are: 1. Review of Resident #4's current FL2 dated	D 276	1.Resident #4 diet was clarified and corrected. Resident #1 physician order was clarified and corrected in ALIS. The corrected diet roster was provided to Dietary. 2. All diet orders reviewed to assure correct in the system. Updated roster provided to Dietary for implementations. Physician orders audited to ensure no inconsistencies. 3. Education was completed immediately for all clinical and the dining team on the process of implementing Diet changes. 4. Education completed 5/4/23 on implementing physician orders. 5. Diet order roster will be readily available for Med tech for SIC and will be monitored for all meals. ED, HWD or designee will review the diet orders upon admission. Any changes will be reviewed by the nurse and DSD. The ED, HWD or designee will review any added or changed diet order to ALIS. DSD will review any diet changes with the culinary team. ED, HWD or designee will Audit. Audits will be done with new orders, weekly x4 weeks and then monthly going forward. Date of compliance is 4/6/2023.	

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D 276	Continued From page 13 01/17/23 revealed: -Diagnoses included Parkinson's disease and dementia. -Resident #4 was intermittently disoriented and his recommended level of care was the Special Care Unit (SCU). Review of Resident #4's diet order dated 02/01/23 revealed an order for a regular diet and thin liquids. Review of Resident #4's Primary Care Provider's (PCP) visit form dated 02/28/23 revealed an order for nectar thick liquids. Observation of Resident #4's lunch meal service on 03/14/23 at 11:38am revealed: -Resident #4 was served a glass of water, a glass of pink lemonade, and a glass of milk prior to the meal being served. -All liquids served during the meal were thin. -Resident #4 drank approximately three-fourths of the glass of water first and coughed once after drinking it. -He then drank approximately half of the pink lemonade and had a single cough after drinking it. -Resident #4 drank two glasses of water, one glass of pink lemonade and a glass of milk during the meal. Interview with the SCU Coordinator (SCC) on 03/14/23 at 11:45am and on 03/17/23 at 8:57am revealed: -She was not aware Resident #4 had an order for thickened liquids until 03/14/23 when survey staff brought it to her attention. -The Health and Wellness Director (HWD) typically gave her a copy of the new diet orders then she would inform the medication aides (MA)	D 276		

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D 276	Continued From page 14 during their morning meeting. -The MAs were responsible for informing the personal care aides (PCA) of any diet order changes. -She kept a list of resident's diet orders in her office and expected the resident's care plan to be updated by the HWD or licensed practical nurse (LPN) when their diet was changed. -There was a breakdown in communication and Resident #4 was not getting thickened liquids as ordered. Observation of Resident #4's lunch meal service on 03/15/23 from 11:24am to 11:51am revealed: -He was served nectar thick water, nectar thick fruit punch, salad, cornbread, cooked brussel sprouts, fried chicken and macaroni and cheese. -A PCA poured him a glass of 2% milk and did not thicken the beverage. -Resident #4 dipped a piece of cornbread in the 2% milk and ate the bread. -He took a large sip of the 2% milk then coughed twice and had a runny nose. Interview with a PCA on 03/15/23 at 11:53am revealed: -She poured Resident #4 the glass of 2% milk and was not aware that he had an order for nectar thick liquids. -She recently started working at the facility and relied on staff with more experience to tell her the residents' diet orders. -She was not sure if there were other ways that new diet orders were communicated to staff. Interview with a second PCA on 03/15/23 at 11:58am revealed the dietary staff thickened Resident #4's beverages in the kitchen and labeled them with his name.	D 276		

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D 276	Continued From page 15 Interview with the Administrator on 03/15/23 at 1:05pm revealed the MA that worked today, 03/15/23, was present for the in service on 03/14/23 and was expected to ensure Resident #4 received thickened liquids at lunch. Interview with the Dietary Manager (DM) on 03/15/23 at 3:09pm revealed: -She received new diet orders from the Administrator or the HWD during their morning meeting. -The new diet orders were kept in the kitchen, either in a binder or posted on a bulletin board. -The HWD printed the therapeutic diet list for the kitchen, but she had access to the facility's electronic record system to look up diet orders if needed. -She had not received a new diet order for Resident #4 since he moved in on 02/03/23 and was not aware he had an order for nectar thick liquids. -She expected the SCU staff to know Resident #4 required nectar thick liquids and to ask the kitchen if they needed beverages thickened. Interview with the Speech Therapist (ST) on 03/16/23 at 1:05pm revealed: -She received an order from Resident #4's PCP on 02/23/23 to evaluate his swallowing due to his history of Parkinson's disease and recent admission to the facility. -Resident #4's diet order on admission was regular texture foods with thin liquids. -She observed Resident #4 consume a meal on 02/28/23 and noticed he experienced dysphagia, coughed and cleared his throat, after drinking thin liquids. -She gave him a cup of nectar thick liquid to drink, and the signs of dysphagia disappeared immediately.	D 276		

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D 276	Continued From page 16 -On 02/28/23, Resident #4's PCP wrote an order for nectar thick liquids. -She observed Resident #4's lunch meal on 03/02/23 and noticed that he was not served thickened liquids. -She asked the PCAs, MAs and kitchen staff if they received a nectar thick liquid order for Resident #4 and they said "no". -On 03/02/23, she told one of MAs working in the SCU that Resident #4 had an order for nectar thick liquids and another order was placed in the HWD's mailbox. -A modified barium swallow study (MBSS) was required to know if Resident #4 had been aspirating thin liquids, but common signs of aspiration included coughing, throat clearing during a meal and wet vocal quality. -Resident #4 was at risk for aspirating but had not had a MBSS yet. Interview with Resident #4's PCP on 03/14/23 at 12:28pm and 03/17/23 at 2:05pm revealed: -Resident #4 had an order from an outside provider for speech therapy when he was admitted to the facility on 02/03/23. -Resident #4 was evaluated by the ST on 02/28/23 and it was recommended he be placed on nectar thickened liquids. -She wrote the order on 02/28/23 while at the facility. -When she wrote a new order for a resident while at the facility, she handed the order to the MA on duty. -She saw Resident #4 on 03/07/23 and staff reported he was coughing during meals. -If Resident #4 was not served thickened liquids he would have an increased risk of aspiration or silent aspiration. Telephone interview with the Regional Registered	D 276		

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D 276	Continued From page 17 Nurse (RN) on 03/17/23 at 1:04pm revealed: -MAs, LPNs or the HWD could receive orders from the PCP when they were in the facility or faxed to the facility. -Whoever received Resident #4's order for nectar thick liquids should have entered it into the facility's electronic record system so the kitchen could see the order. Interview with the Administrator on 03/14/23 at 1:05pm and on 03/17/23 at 3:13pm revealed: -The facility did not have an HWD and it was the HWD's responsibility to give the DM a copy of new diet orders, enter the order into the facility's electronic record system and inform the MAs as well of the PCAs of the new diet order. -Since the facility did not have an HWD, it was her responsibility to ensure the DM, MAs and PCAs knew about new diet orders. 2. Review of Resident #1's current FL2 dated 05/04/22 revealed: -Diagnoses included unspecified insomnia, unspecified dementia and cognitive communication deficit. -An order for melatonin 3 mg (a medication used for sleeplessness), 2 tablets at bedtime. Review of Resident #1's signed PCP's orders dated 11/30/22 revealed an order for melatonin 3 mg, 2 tablets at bedtime. Review of Resident #1's January 2023, February 2023 and March 2023 electronic medication administration record (eMAR) revealed: -An entry for melatonin 3 mg, 2 tablets at bedtime, scheduled at 8:00pm. -Melatonin 3 mg, 2 tablets at bedtime was documented as administered from 01/01/23 through 03/14/23.	D 276		

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D 276	Continued From page 18 Observation of Resident #1's medications on hand on 03/15/23 at 12:42pm revealed: -Resident #1's medications were packaged in plastic pouches based on the date and what time they were scheduled to be administered. -The name, dose, quantity and order for each medication was printed on the corresponding pouch. -Melatonin 3 mg take one tablet at bedtime was printed on the 10:00pm medication pouch. -There was 1 tablet of melatonin 3 mg in a 10:00pm medication pouch. Telephone interview with a Pharmacist at Resident #1's pharmacy on 03/15/23 at 3:15pm revealed: -Resident #1's most recent order for melatonin 3 mg was signed on 03/09/23 and it was written for 1 tablet at bedtime. -The pharmacy did not receive the physician's order dated 11/30/22 for melatonin 3 mg, 2 tablets at bedtime. Interview with a MA on 03/16/23 at 3:45pm revealed: -Resident #1 used a PCP that did not contract with the facility and they sent electronic orders to the pharmacy for her medications. -She did not fax any medication orders to Resident #1's pharmacy. Interview with a second MA on 03/17/23 at 11:15am revealed: -She sent signed medication orders to the pharmacy. -She did not remember sending Resident #1's PCP's orders that were signed on 11/30/22 to the pharmacy.	D 276		

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D 276	Continued From page 19 Telephone interview with the Regional RN on 03/17/23 at 1:04pm revealed: -MAs, LPNs and the HWD could receive orders from the PCP when Resident #1's family brought in the paperwork or when they were faxed to the facility. -Whoever received Resident #1's order for melatonin 3 mg that was dated 11/30/22, should have sent it to her pharmacy to be filled. Interview with the Administrator on 03/17/23 at 2:53pm revealed: -Resident #1's order for melatonin 3 mg that was dated 11/30/22 was signed while the previous HWD was here, and she should have sent that order to the pharmacy. -The HWD was responsible for auditing the residents' records, but she was not sure how often that occurred. -The residents' records have not been audited since the last HWD quit in February 2023. Attempted telephone interview with Resident #1's PCP on 03/17/23 at 12:19pm was unsuccessful. The facility failed to ensure a physician's order for nectar thick liquids was implemented for 13 days after it was written, for a resident who experienced dysphagia when consuming thin liquids (Resident #4) which led to an increased risk of aspiration. This failure placed the resident at substantial risk for physical harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/14/23. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 16,	D 276		

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D 276	Continued From page 20 2023.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents (#1, #2, and #5) related to a medication for irregular heart rhythm, edema (swelling due to fluid retention), depression, and fungal infection (#5), a medication to help lower mealtime blood sugar spikes, a medication to treat fluid retention (edema) and swelling (#2) and a medication for sleeplessness (#1). The findings are: 1. Review of Resident #5's current FL2 dated 03/17/22 revealed diagnoses included Alzheimer's disease and dementia. a. Review of Resident 5's signed Primary Care Provider (PCP) orders dated 12/20/22 revealed there was an order for atenolol 25mg (a medication to treat hypertension and irregular	D 358	1.The identified deficiencies for Residents #1, #2, and #5 have been corrected. Med Error documentation was completed for each issue identified. Appropriate notification was communicated to the Physician for review of current orders. The Insulin parameter issue with order for resident #2 was clarified and corrected. 2. ED, HWD or designee conducted a review of all insulin orders for accuracy immediately. All parameters for SS metrics were corrected. Review of MARS for all residents to identify any additional medication management issues. Appropriate notification was initiated as indicated. 3.Education was provided for all Nursing staff including Med Tech's and Nurses on the 6 rights of medication administration along with appropriate documentation and follow up. Pharmacy, HWD or designee will be the only entities to enter orders on the MAR profile. HWD or designee will review all new medication to ensure accuracy after pharmacy profile is complete. 4.ED, HWD or designee will provide monthly education and training on insulin. The ED, HWD or Designee will monitor for compliance. Monitoring will be with all new order implementation, and weekly going forward. Date of Compliance 5/1/23.	

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D 358	Continued From page 21 heart rhythm), one tablet daily. Review of an electronically signed PCP order for Resident #5 dated 01/07/23 revealed atenolol 25mg, one-half tablet (12.5mg) daily. Review of a PCP order for Resident #5 dated 01/24/23 revealed atenolol 12.5mg daily was discontinued. Review of a PCP order for Resident #5 dated 01/31/23 revealed atenolol 12.5mg, one tablet every other day; to be started 01/31/23. Review of a PCP order for Resident #5 dated 02/07/23 revealed: -Atenolol 12.5mg every other day was to be discontinued. -Atenolol 12.5mg one tablet daily was to be started. Review of an electronically signed PCP order for Resident #5 dated 02/09/23 revealed atenolol 25mg, one-half tablet was to be administered every other day. Review of a PCP order for Resident #5 dated 02/14/23 revealed atenolol 12.5mg daily was to be discontinued. Review of Resident #5's January 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry dated 04/01/22 for atenolol 25mg one tablet daily with a discontinue date of 01/14/23. -There was documentation atenolol 25mg was administered at 9:00am from 01/01/23 through 01/09/23 and 01/11/23 through 01/14/23. -There was no documentation atenolol 25mg was	D 358		

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D 358	Continued From page 22 administered at 9:00am on 01/10/23. -The reason for the discontinuation was "duplicate". -There was an entry dated 01/07/23 for atenolol 25mg one-half tablet daily with a discontinue date of 01/24/23. -There was documentation atenolol 25mg one-half tablet was administered at 9:00am from 01/10/23 through 01/19/23 and 01/21/23 through 01/24/23. -There was documentation atenolol 25mg one-half tablet was not administered on 01/20/23 due to resident was out of the facility. -The entry was discontinued as ordered by the PCP. -There was an entry dated 01/31/23 for atenolol 12.5mg one tablet every other day. -There was an entry dated 01/31/23 for atenolol 25mg one-half tablet every other day. Review of Resident #5's February 2023 eMAR revealed: -There was an entry dated 01/31/23 for atenolol 12.5mg one tablet every other day with a discontinue date of 02/06/23. -There was documentation atenolol 12.5mg was administered at 9:00am on 02/02/23, 02/04/23, and 02/06/23. -The entry was discontinued as ordered by the PCP. -There was an entry dated 01/31/23 for atenolol 25mg one-half tablet every other day with a discontinue date of 02/08/23. -There was documentation atenolol 25mg one-half tablet was administered at 9:00am on 02/02/23, 02/04/23, 02/06/23, and 02/08/23. -The entry was discontinued as ordered by the PCP. -There was an entry dated 02/08/23 for atenolol 25mg one-half tablet daily with a discontinue date	D 358		

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D 358	Continued From page 23 of 02/14/23. -There was documentation atenolol 25mg one-half tablet was administered at 9:00am from 02/09/23 through 02/14/23. -The entry was discontinued as ordered by the PCP. -There was an entry dated 02/09/23 for atenolol 25mg one-half tablet every other day with a discontinue date of 02/14/23. -There was documentation atenolol 25mg one-half tablet was administered at 9:00am on 02/11/23 and 02/13/23. -The entry was discontinued as ordered by the PCP. Interview with a medication aide (MA) on 03/16/23 at 10:22am revealed: -When she received a new order she entered it into the resident's eMAR and faxed it to pharmacy. -When pharmacy received an order, they put the order on the resident's eMAR. -Because of the process there were often duplicate entries in the residents' eMARs. -The Special Care Unit Coordinator (SCC) was aware of the duplicates. Telephone interview on 03/16/23 at 11:57am with a representative from the facility's contracted pharmacy revealed: -Facility staff and pharmacy staff were able to enter orders into resident eMARs. -Pharmacy staff did not recommend facility staff enter orders into the resident eMARs because the pharmacy could not view orders the facility entered, and it could cause duplicate entries. -The pharmacy received an order dated 06/28/22 for Resident #5 for atenolol 25mg one tablet daily and 30 tablets were last dispensed 12/17/22. -The pharmacy received an order on 01/09/23 for	D 358		

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D 358	Continued From page 24 Resident #5 for atenolol 25mg one-half tablet daily and 30 half tablets were dispensed 01/09/23. -The pharmacy received an order on 02/01/23 for Resident #5 for atenolol 25mg one-half tablet every other day and 15 half tablets were dispensed 02/01/23. -The pharmacy received an order on 02/12/23 for Resident #5 for atenolol 25mg one half tablet every other day and 30 half tablets were dispensed 02/12/23. -The pharmacy received an order on 02/14/23 for Resident #5 to discontinue atenolol 12.5mg. Telephone interview with Resident #5's PCP on 03/17/23 at 2:05pm revealed: -She handed a paper copy of any new orders she wrote while at the facility to the MA on duty. -She tried to review resident eMARs when she was in the facility but found them confusing. -She sometimes saw duplicate orders on resident eMARs and stated it was a dangerous system. -She saw Resident #5 on 01/03/23 and wrote an order at the facility to decrease his atenolol to 12.5mg daily because his heart rate was low at 46 beats per minute (bpm). -On 01/24/23 Resident #5's heart rate was 48 bpm, so she discontinued his atenolol. -On 01/31/23 she wrote an order for Resident #5 to receive atenolol 12.5mg every other day because he started having symptoms of heart palpitations and atrial fibrillation. -On 02/07/23 Resident #5 had an irregular heart rhythm and she wrote an order for atenolol 12.5mg daily and for the resident to follow up with cardiology. -Resident #5 saw cardiology on 02/13/23. -On 02/14/23 she discontinued his atenolol and started metoprolol ER 25mg one-half tablet daily per their recommendations.	D 358		

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D 358	Continued From page 25 -If Resident #5 received too much atenolol it could cause bradycardia (low heart rate) which she had observed in Resident #5. b. Review of Resident 5's signed PCP orders dated 12/20/22 revealed: -There was an order for torsemide (a medication to treat fluid retention) 20mg, two tablets daily scheduled at 9:00am. -There was an order for torsemide 20mg, one tablet daily at noon. Review of a clarified PCP order for Resident #5 dated 01/31/23 revealed: -Torsemide 20mg two tablets, administer daily in the morning. -Torsemide 20mg one tablet, administer daily at noon. Review of a PCP order for Resident #5 dated 02/14/23 revealed torsemide 20mg, one tablet was to be administered daily at noon for seven days and then discontinue. Review of Resident #5's January 2023 eMAR revealed: -The was an entry dated 08/31/22 for torsemide 20mg two tablets at 9:00am and one tablet at 12:00pm with a discontinue date of 01/03/23. -There was documentation torsemide 20mg two tablets were administered at 9:00am on 01/01/23 and 01/02/23. -There was no documentation torsemide 20mg one tablet was administered at 12:00pm. -The reason for the discontinuation was "duplicate". -There was an entry dated 11/08/22 for torsemide 20mg two tablets at 9:00am and one tablet daily at 12:00pm. -There was documentation torsemide 20mg two	D 358		

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D 358	Continued From page 26 tablets were administered at 9:00am from 01/21/23 through 01/31/23. -There was no documentation torsemide 20mg two tablets were administered at 9:00am from 01/01/23 through 01/20/23. -There was documentation torsemide 20mg one tablet was administered at 12:00pm from 01/01/23 through 01/19/23. -There was no documentation torsemide 20mg one tablet was administered at 12:00pm from 01/20/23 through 01/31/23. -There was an entry dated 01/03/23 for torsemide 20mg two tablets daily at 9:00am with a discontinue date of 01/14/23. -There was documentation torsemide 20mg two tablets were administered at 9:00am from 01/03/23 through 01/14/23. -The reason for the discontinuation was "duplicate". -There was an entry dated 01/31/23 for torsemide 20mg two tablets daily at 9:00am. Review of Resident #5's February 2023 eMAR revealed: -There was an entry dated 11/08/22 for torsemide 20mg two tablets daily and contained two administration times, 9:00am and 12:00pm with a discontinuation date of 02/03/23. -There was documentation torsemide 20mg two tablets were administered at 9:00am from 02/01/23 through 02/03/23 and at 12:00pm on 02/01/23 and 02/02/23. -The reason for the discontinuation was the order was discontinued on 01/03/23. -There was an entry dated 01/31/23 for torsemide 20mg two tablets every morning. -There was documentation torsemide 20mg two tablets were administered at 9:00am from 02/01/23 through 02/23/23 and from 02/25/23 through 02/28/23.	D 358		

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D 358	Continued From page 27 -There was documentation torsemide 20mg two tablets was not administered at 9:00am on 02/24/23 because it was on hold per physician's orders. -There was an entry dated 02/01/23 for torsemide 20mg one tablet daily at 12:00pm and contained two administration times, 9:00am and 12:00pm with a discontinuation date of 02/06/23. -There was documentation torsemide 20mg one tablet was administered at 9:00am from 02/04/23 through 02/06/23. -There was no documentation torsemide 20mg one tablet was administered at 9:00am from 02/01/23 through 02/03/23. -There was documentation torsemide 20mg one tablet was administered at 12:00pm on 02/01/23 and 02/02/23. -There was no documentation torsemide 20mg one tablet was administered at 12:00pm from 02/03/23 through 02/06/23. -The reason for the discontinuation was "duplicate". -There was an entry dated 02/14/23 for torsemide 20mg one tablet daily at 12:00pm for seven days then discontinue. -There was documentation torsemide 20mg one tablet was administered at 12:00pm from 02/18/23 through 02/23/23 and from 02/25/23 through 02/28/23. -There was documentation torsemide 20mg one tablet was not administered at 12:00pm on 02/24/23 because it was on hold per physician's orders. Review of Resident #5's March 2023 eMAR revealed: -There was an entry dated 01/31/23 for torsemide 20mg two tablets every morning. -There was documentation torsemide 20mg two tablets were administered at 9:00am from	D 358		

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D 358	Continued From page 28 03/01/23 through 03/14/23. -There was an entry dated 02/14/23 for torsemide 20mg one tablet daily at 12:00pm for seven days then discontinue. -There was documentation torsemide 20mg one tablet was administered at 12:00pm from 03/02/23 through 03/13/23. -There was documentation torsemide 20mg one tablet was not administered at 12:00pm on 03/01/23 and 03/14/23 because the resident was out of the facility. Observation on 03/16/23 at 10:18am of medications on hand for Resident #5 revealed: -There was a bubble pack of torsemide 20mg with 18 tablets remaining. -The label indicated 90 tablets were dispensed on 01/31/23. -The instructions were to administer two tablets every morning and one tablet at noon. Telephone interview on 03/16/23 at 11:57am with a representative from the facility's contracted pharmacy revealed: -Resident #5 had an order dated 12/31/22 for torsemide 20mg, two tablets daily in the morning and one tablet daily at 12:00pm. -The pharmacy dispensed torsemide 20mg, 90 tablets on 12/31/22 and 01/31/23. -The pharmacy received an order on 02/21/23 to discontinue Resident #5's torsemide. Telephone interview with Resident #5's PCP on 03/17/23 at 2:05pm revealed: -Torsemide was prescribed for Resident #5 for edema and congestive heart failure. -She saw Resident #5 on 01/31/23 and he had increased edema in his legs. -She reviewed his eMAR at that time (01/31/23) and did not see documentation torsemide 20mg,	D 358		

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D 358	Continued From page 29 one tablet was being administered at 12:00pm and believed that was the reason she wrote the clarification order dated 01/31/23. c. Review of Resident #5's signed orders dated 12/20/22 revealed: -There was an order for trazodone 50mg, one-half tablet daily at 7:00am and 1:00pm -There was an order for trazodone 50mg, three tablets at bedtime. Review of Resident #5's January 2023 eMAR revealed: -There was an entry dated 04/07/22 for trazodone 50mg three tablets at bedtime with a discontinue date of 01/03/23. -There was documentation trazodone 50mg three tablets were administered at 9:00pm on 01/01/23 and 01/02/23. -The reason for the discontinuation was "duplicate". -There was an entry dated 04/11/22 for trazodone 50mg one-half tablet at 7:00am and 1:00pm and three tablets at 9:00pm. -There was documentation trazodone 50mg one-half tablet was administered at 7:00am and 1:00pm on 01/01/23 and 01/02/23 and trazodone 50mg three tablets were administered at 9:00pm from 01/03/23 through 01/31/23. -There was no documentation trazodone 50mg one-half tablet was administered at 7:00am and 1:00pm from 01/03/23 through 01/31/23. -There was no documentation trazodone 50mg three tablets were administered at 9:00pm on 01/01/23 and 01/02/23. Review of Resident #5's February 2023 eMAR revealed: -There was an entry dated 12/31/22 for trazodone 50mg three tablets at bedtime.	D 358		

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D 358	Continued From page 30 -There was documentation trazodone 50mg three tablets were administered at 9:00pm from 02/01/23 through 02/28/23. Review of Resident #5's March 2023 eMAR revealed: -There was an entry dated 12/31/22 for trazodone 50mg three tablets at bedtime. -There was documentation trazodone 50mg three tablets were administered at 9:00pm from 03/01/23 through 03/13/23. Observation on 03/16/23 at 10:18am of medications on hand for Resident #5 revealed: -There were two bubble packs of trazodone. -One bubble pack contained half tablets of trazodone 50mg, dispensed on 12/16/22 with eleven half-tablets remaining. -The directions were to administer one-half tablet daily at 7:00am and daily at 1:00pm and take three tablets at bedtime. -The second bubble pack contained trazodone 50mg tablets, dispensed on 01/31/23 and had 30 tablets remaining. -The directions were to administer one-half tablet by mouth daily at 7:00am and daily at 1:00pm and take three tablets at bedtime. Interview with the MA on 03/16/23 at 10:22am revealed: -She did not administer trazodone to Resident #5 on her shift. -She had not looked at the trazodone label because it was not on the resident's eMAR for her to administer. Telephone interview on 03/16/23 at 11:57am with a representative from the facility's contracted pharmacy revealed: -Resident #5 had an order dated 04/07/22 for	D 358		

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D 358	Continued From page 31 trazodone 50mg, one-half tablet daily at 7:00am and 1:00pm and three tablets daily at bedtime. -Trazodone 50mg, 120 tablets were dispensed for Resident #5 on 09/07/22, 12/16/22, and 1/31/23. Telephone interview with Resident #5's PCP on 03/17/23 at 2:05pm revealed Resident #5 was admitted to the facility with the current trazodone order, and it was usually prescribed for depression and to help with sleep. d. Review of a PCP order for Resident #5 dated 01/24/23 revealed fluconazole 150mg, one tablet was to be administered every 72 hours for three doses. Review of Resident #5's PCP order dated 02/14/23 revealed fluconazole 150mg was to be discontinued. Review of Resident #5's January 2023 eMAR revealed: -There was an entry dated 01/25/23 for Diflucan 150mg (equivalent to fluconazole) one tablet every 72 hours for three doses with a discontinue date of 01/28/23. -There was documentation Diflucan 150mg one tablet was administered at 8:00am from 01/25/23 through 01/27/23. -The reason for the discontinuation was the order was completed. -There was an entry dated 01/24/23 for fluconazole 150mg one tablet every 72 hours for three doses. -The was documentation fluconazole 150mg one tablet was administered at 8:00am on 01/27/23. -On 01/30/23, an exception was documented indicating the resident had not received the medication.	D 358		

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D 358	Continued From page 32 Review of Resident #5's nursing progress note dated 01/30/23 revealed the course of fluconazole 150mg was completed. Review of Resident #5's February 2023 eMAR revealed: -There was an entry dated 01/24/23 for fluconazole 150mg one tablet every 72 hours for three doses with a discontinue date of 02/17/23. -There was documentation fluconazole 150mg one tablet was administered at 8:00am on 02/02/23 and 02/08/23. -There was documentation fluconazole 150mg was not administered on 02/05/23 because the order was completed. -There was documentation dated 02/11/23 and 02/14/23 fluconazole 150mg was not administered because the medication was not available. -Fluconazole was documented as discontinued on 02/17/23. Telephone interview on 03/16/23 at 11:57am with a representative from the facility's contracted pharmacy revealed they received an order for Resident #5 on 01/24/23 for fluconazole 150mg, one tablet every 72 hours for three doses and three tablets were dispensed that day (01/24/23). Telephone interview with Resident #5's PCP on 03/17/23 at 2:05pm revealed: -She prescribed fluconazole for the resident on 01/24/23 because he had a yeast infection. -The fluconazole was to be administered every three days because it could cause liver damage if administered more frequently. -She wrote the discontinue order on 02/14/23 because when she looked at the resident's February 2023 eMAR it appeared he was to receive it every 72 hours.	D 358		

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D 358	Continued From page 33 Refer to interview with a MA on 03/15/23 at 3:54pm. Refer to telephone interview with the Regional Registered Nurse (RN) on 03/17/23 at 1:04pm. Refer to interview with Administrator on 03/17/23 at 3:13pm. 2. Review of Resident #2's current FL2 dated 03/17/2022 revealed diagnoses included diabetes mellitus, hypertension, congestive heart failure, chronic kidney disease, and lymphedema. a. Review of Resident #2's current signed physician orders dated 11/01/22 revealed Novolog Flexpen 100/ml, check fingerstick blood sugar (FSBS) before each meal and at bedtime and inject per sliding scale: FSBS: less than 80 = 0 units, 80-150 = 4 units, 150-200 = 6 units, 201-250 = 8 units, 251-300 = 10 units, 301-350 = 12 units, greater than 350 give 14 units and call PCP if persistent FSBS greater than 350. Review of Resident #2's February 2023 eMAR revealed: -His FSBS on 02/02/23 before dinner was 273 and he received 12 units of Novolog Flexpen 100 units, when he should have received 10 units. -His FSBS on 02/05/23 before lunch was 184 and he received 4 units of Novolog Flexpen 100 units, when he should have received 6 units. -His FSBS on 02/07/23 before breakfast was 170 and he received 4 units of Novolog 100 units, when he should have received 6 units. -His FSBS on 02/08/23 before breakfast was 189 and he received 4 units of Novolog 100 units, when he should have received 6 units. -His FSBS on 02/09/23 before breakfast was 189	D 358		

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D 358	Continued From page 34 and he received 4 units of Novolog 100 units, when he should have received 6 units. -His FSBS on 02/14/23 before lunch was 289 and he received 8 units of Novolog 100 units, when he should have received 10 units. -His FSBS on 02/17/23 before lunch was 261 and he received 12 units of Novolog 100 units, when he should have received 10 units. -His FSBS on 02/18/23 before breakfast was 163 and he received 4 units of Novolog 100 units, when he should have received 6 units. -His FSBS on 02/22/23 before lunch was 182 and he received 4 units of Novolog 100 units, when he should have received 6 units. -His FSBS on 02/25/23 before dinner was 235 and he received 10 units of Novolog 100 units, when he should have received 8 units. Review of Resident #2's March 2023 eMAR revealed his FSBS on 03/12/23 before lunch was 264 and he received 12 units of Novolog 100 units, when he should have received 10 units. Interview with the MA on 03/16/23 at 4:52pm revealed: -If the sliding scale order was checked each time, the Novolog would have been given correctly. -She thought the Regional RN was auditing the charts since December when the HWD resigned but was not sure. Interview with Resident #2 on 03/17/23 at 9:50am revealed: -He always had a FSBS check before meals and before he went to bed. -He did not know what his insulin dose was but knew he always had to get Novolog before his meals but not at bedtime. -He went out of the facility quite a bit with his family member and ate lunch out many times and	D 358		

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D 358	Continued From page 35 never paid attention to what he ate. -He never felt any different after he received his Novolog than he did before he received it. Interview with the MA on 03/17/23 at 11:40am revealed: -She tried to be careful administering sliding scale insulin because the amount of units administered had to documented. -The Novolog units that were administered had to be documented in another area on the eMAR because there was no place for it to be documented. Interview with the Administrator on 03/17/23 at 3:13 pm revealed: -She did not know there were errors on Resident #2's sliding scale insulin. -The HWD was responsible for the auditing process but she thought the Regional RN was doing it since the HWD resigned in December 2022. -The MAs should be checking the orders each time medications were given. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 03/17/23 at 12:06pm revealed: -Resident #2's current sliding scale insulin order was Novolog Flexpen 100/ml, check FSBS before each meal and at bedtime and inject per sliding scale: FSBS: less than 80 = 0 units, 80-150 = 4 units, 151-200 = 6 units, 201-250 = 8 units, 251-300 = 10 units, 301-350 = 12 units, greater than 350 give 14 units and call PCP if persistent FSBS greater than 350. -If not enough sliding scale insulin was given, blood sugars could be higher throughout the day and the resident could possibly have nausea and vomiting, agitation, be drowsy and eventually	D 358		

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D 358	Continued From page 36 cause nerve damage and/or neuropathy. -If too much sliding scale insulin was given the resident could be disoriented, but this would be over a period of time. Attempted telephone interview with Resident #2's PCP on 03/16/23 at 10:49am was unsuccessful. Attempted telephone interview with Resident #2's Endocrinologist on 03/17/23 at 10:26am was unsuccessful. b. Observation of Resident #2's medications on hand on 03/15/23 at 4:45pm revealed: -A bubble pack of metolazone 2.5mg, take 1 tab by mouth every day as needed (prn) for weight gain over 3 pounds. -The bubble pack had 25 of 30 tablets left. -The medication was ordered on 11/22/22 by Resident #2's nephrologist. -The bubble pack dispense date was 11/22/22 with 30 tablets dispensed. Review of Resident #2's January 2023 eMAR revealed: -There was not an entry for metolazone 2.5 mg, 1 tablet daily prn for weight gain over 3 pounds. -There was documentation on 01/16/23 he weighed 238 pounds, a gain of 6 pounds from the previous day. -There was documentation on 01/25/23 he weighed 231.8 pounds, a gain of 5.2 pounds from the previous day. -There was documentation on 01/29/23 he weighed 225.2 pounds, a gain of 5.4 pounds from the previous day. Review of Resident #2's February 2023 eMAR revealed: -There was not an entry for metolazone 2.5mg, 1	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060171	A. BUILDING: _____ B. WING _____	R 03/17/2023

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D 358	Continued From page 37 tablet daily prn for weight gain over 3 pounds. -There was documentation on 02/06/23 he weighed 235 pounds, a gain of 4.4 pounds from the previous day. -There was documentation on 02/08/23 he weighed 245.4 pounds, a gain of 19.8 pounds from the previous day. -There was documentation on 02/11/23 he weighed 229 pounds, a gain of 6 pounds from the previous day. Review of Resident #2's March 2023 eMAR revealed: -There was not an entry for metolazone 2.5mg, 1 tablet daily prn for weight gain over 3 pounds. -There was documentation on 03/08/23 he weighed 227.8 pounds, a gain of 4.2 pounds from the previous day. -There was documentation on 03/12/23 he weighed 232.4 pounds, a gain of 6.6 pounds from the previous day. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/16/23 at 9:40am revealed: -Metolazone 2.5mg, take 1 tab by mouth everyday prn for weight gain over 3 pounds was still an active order. -Resident #2's metolazone 2.5mg prn was an e-script that was sent to the pharmacy on 11/22/22. -Resident #2's metolazone 2.5mg prn was last dispensed on 11/22/22 for 30 tablets. -The pharmacy technician did not know how the metolazone 2.5mg prn was omitted from the January 2023, February 2023, and March 2023 eMAR's. Interview with a facility licensed practical nurse (LPN) on 03/16/23 at 1:31pm revealed:	D 358		

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D 358	Continued From page 38 -When a new order came in from the PCP, the order was faxed to the pharmacy and the pharmacy would put it on the eMAR. -She had never given metolazone 2.5mg prn to Resident #2 because it was not on the eMAR. -She thought the Regional RN was doing medication cart audits. Interview with a MA on 03/16/23 at 4:52pm revealed: -She had never given metolazone 2.5mg prn to Resident #2 because it was not on the eMAR. -The only time a medication was removed from the eMAR was when it was discontinued, or if the order was removed by the pharmacy. - If the medication was discontinued, the facility would fax the order to the pharmacy, and the pharmacy would remove it. -She did not remember seeing the metolazone 2.5mg prn in the medication cart. -The HWD used to audit the eMAR's before she left but does not know who does it now. Interview with Resident #2 on 03/17/23 at 9:50am revealed: -He was weighed everyday but sometimes he would refuse because he did not want to get out of bed. -He felt he did not need to be weighed but the PCP told him he had to because of his breathing. -He never felt any discomfort because of swelling or excess weight and stayed about the same weight everyday. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 03/17/23 at 12:06pm revealed: -Resident #2 had an active order to give metolazone 2.5mg 1 tab by mouth everyday prn for weight gain over 3 pounds.	D 358		

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D 358	Continued From page 39 -The consequences of not getting the metolazone 2.5mg prn for weight gain over 3 pounds could be retention of fluid, edema and could cause pressure on his veins which could lead to discomfort. -He did not know how the metolazone 2.5mg prn was omitted on the January 2023, February 2023, and March 2023 eMAR's. -Interview with the Administrator on 03/17/23 at 3:13pm revealed: -She did not know Resident #2 was not getting metolazone 2.5mg 1 tab by mouth everyday prn for weight gain over 3 pounds. -The facility could not find a discontinued order for metolazone 2.5mg prn. -She did not know how metolazone 2.5mg prn could have dropped off the January 2023, February 2023 and March 2023 eMARs. -The HWD was responsible for the auditing process but she thought the Regional RN was doing it since the HWD left in December 2022. Attempted telephone interview with Resident #2's PCP on 03/16/23 at 10:49am was unsuccessful. Attempted telephone interview with Resident #2's Nephrologist on 03/17/23 at 10:44am was unsuccessful. Refer to telephone interview with the Regional RN on 03/17/23 at 1:04pm. Refer to interview with Administrator on 03/17/23 at 3:13pm. 3. Review of Resident #1's current FL2 dated 05/04/22 revealed: -Diagnoses included unspecified insomnia and unspecified dementia.	D 358		

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D 358	Continued From page 40 -An order for melatonin 3 mg (a medication for sleeplessness), 2 tablets at bedtime. Review of Resident #1's signed PCP orders dated 11/30/22 revealed an order for melatonin 3 mg, 2 tablets at bedtime. Review of Resident #1's January 2023 eMAR revealed: -There was an entry dated 05/06/22 for melatonin 3 mg, 2 tablets at bedtime, scheduled at 8:00pm. -Melatonin 3 mg, 2 tablets at bedtime was documented as administered from 01/01/23 through 01/31/23. -There was documentation dated 01/21/23, "only one 3 mg tablet in the pack". Review of Resident #1's February 2023 eMAR revealed: -There was an entry dated 05/06/22 for melatonin 3 mg, 2 tablets at bedtime, scheduled at 8:00pm. -Melatonin 3 mg, 2 tablets at bedtime was documented as administered from 02/01/23 through 02/28/23. Review of Resident #1's March 2023 eMAR revealed: -There was an entry dated 05/06/22 for melatonin 3 mg, 2 tablets at bedtime, scheduled at 8:00pm. -Melatonin 3 mg, 2 tablets at bedtime were documented as administered from 03/01/23 through 03/14/23. Observation of Resident #1's medications on hand on 03/15/23 at 12:42pm revealed: -Resident #1's medications were packaged in plastic pouches based on the date and what time they were scheduled to be administered. -The name, dose, quantity and order for each medication was printed on the corresponding	D 358		

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D 358	Continued From page 41 pouch. -Melatonin 3 mg take one tablet at bedtime was printed on the 10:00pm medication pouch. -There was 1 tablet of melatonin 3 mg in a 10:00pm medication pouch. Telephone interview with a Pharmacist at Resident #1's pharmacy on 03/15/23 at 3:54pm revealed: -The pharmacy had an order for melatonin 3 mg, 1 tablet at bedtime signed on 10/21/22. -They did not receive an order for melatonin 3 mg, 2 tablets at bedtime signed on 11/30/22. -The pharmacy had never dispensed melatonin 3 mg with two tablets to take at bedtime for Resident #1. Interview with a MA on 03/15/23 at 3:45pm revealed: -She knew Resident #1's melatonin dosage available for administration did not match the dosage on the eMAR and the HWD contacted the pharmacy about it before she resigned in December 2022. -The pharmacy never sent two tablets of melatonin 3 mg for Resident #1 and the HWD no longer worked at the facility. -She had not followed up with Resident #1's pharmacy because she forgot. -She did not follow up with Resident #1's PCP because she worked second shift and was not successful in reaching providers in the late afternoon. Interview with Resident #1 on 03/16/23 at 8:50am revealed she was not aware that she was supposed to take two tablets of melatonin at bedtime. Refer to interview with a MA on 03/15/23 at	D 358		

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D 358	Continued From page 42 3:45pm. Refer to telephone interview with the Regional RN on 03/17/23 at 1:04pm. Refer to interview with the Administrator on 03/17/23 at 3:13pm. Interview with a MA on 03/15/23 at 3:45pm revealed: -She completed cart audits, whenever she was asked, which involved checking expiration dates of medications and making sure the medication labels matched the medication orders on the eMAR. -If there was a discrepancy between the medication label and the eMAR, she contacted the resident's PCP and/or pharmacy. Telephone interview with the Regional RN on 03/17/23 at 1:04pm revealed: -The MAs and LPNs should compare the medication labels with the eMAR and ensure that they match every time they administer medication. -The LPNs should audit the eMARs daily to make sure all the medications were administered. -She and the other Regional RN remotely audited the eMARs on a weekly basis and looked at the orders that were uploaded in the facility's electronic record system. -The clinical staff were expected to audit the medication orders. Interview with the Administrator on 03/17/23 at 3:13pm revealed: -She expected the MAs and LPNs to audit the medication carts but she was not sure how often it should be completed. -The HWD was responsible for the auditing	D 358		

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D 358	Continued From page 43 process, but she thought the Regional RN was doing the auditing since the HWD resigned in December 2022. -She was not sure of everything the auditing process was supposed to include. _____ The facility failed to administer medications as ordered resulted in Resident #5 not receiving the correct dose of atenolol ordered to treat irregular heart rhythm which caused bradycardia and not receiving a medication used to treat a fungal infection as scheduled which could have caused liver damage. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/16/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 01, 2023.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 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; (5) reason or justification for the administration of medications or treatments as needed (PRN) and	D 367	1.The identified deficiencies for Residents #1 and #2 have been corrected. Med Error documentation was completed for each issue identified. Appropriate notification was communicated to the Physician for review of current orders. 2. ED, HWD or designee conducted a review of all resident MARs for accuracy immediately. All Medication administration errors were corrected. Review of MARS for all residents to identify any additional medication management issues. Appropriate notification was initiated as indicated. 3.Education was provided for all Nursing staff including Med Tech's and Nurses on the 6 rights of medication administration along with appropriate documentation and follow up. Pharmacy, HWD or designee will be the only entities to enter orders on the MAR profile. HWD or designee will review all new medication to ensure accuracy after pharmacy profile is complete. 4.ED, HWD or designee will provide monthly education and training on the Medication Administration Record. The ED, HWD or Designee will monitor for compliance daily going forward. Date of Compliance 5/1/23.	

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D 367	Continued From page 44 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 the 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 evidenced by: Based on interviews, observations and record reviews, the facility failed to ensure electronic medication administration records (eMAR) were accurate for 2 of 5 residents (Resident #1 and #2) related to documenting the amount of insulin administered (#2), not including a medication used for overactive bladder (#1) and an incorrect order for a medication used for sleeplessness (#1). The findings are: Review of Resident #2's current FL2 dated 03/17/22 revealed diagnoses included diabetes mellitus, hypertension, congestive heart failure (CHF), chronic kidney disease, and lymphedema. Review of Resident #2's current signed physician orders dated 11/01/22 revealed: -Novolog Flexpen --100/ml, check fingerstick blood sugar (FSBS) before each meal and at bedtime and inject per sliding scale: FSBS: less than 80 = 0 units, 80-150 = 4 units, 150-200 = 6 units, 201-250 = 8 units, 251-300 = 10 units, 301-350 = 12 units, greater than 350 give 14 units and call Primary Care Physician (PCP) if persistent FSBS greater than 350.	D 367		

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D 367	Continued From page 45 -Check FSBS daily at 7:00am, 11:00am, 4:00pm and 8:00pm. Review of Resident #2's January 2023 eMAR revealed: -There was an order for Novolog Flexpen 100/ml, inject subcutaneously before meals per sliding scale: if less than 80 = 0 units, 80-150 = 4 units, 150-200 = 6 units, 201-250 = 8 units, 251-300 = 10 units, 301-350 = 12 units, greater than 350 give 14 units and call PCP if persistent FSBS greater than 350. -There was an entry to check FSBS before meals and at bedtime. -There was an entry for Novolog 100/ml to be given per sliding scale order. -There were 93 opportunities with FSBS needing Novolog in January 2023. -There were 19 instances where Novolog was given but the amount of Novolog was not documented in the eMAR. Review of Resident #2's February 2023 eMAR revealed: -There was an order for Novolog Flexpen 100/ml, inject subcutaneously before meals per sliding scale: if less than 80 = 0 units, 80-150 = 4 units, 150-200 = 6 units, 201-250 = 8 units, 251-300 = 10 units, 301-350 = 12 units, greater than 350 give 14 units and call PCP if persistent FSBS greater than 350. -There was an entry to check FSBS before meals and at bedtime. -There was an entry for Novolog 100/ml to be given per sliding scale order. -There were 81 opportunities with FSBS needing Novolog in February 2023. -There were 12 instances where Novolog was given but the amount of Novolog was not documented in the eMAR.	D 367		

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D 367	Continued From page 46 Review of Resident #2's March 2023 eMAR revealed: -There was an order for Novolog Flexpen 100/ml, inject subcutaneously before meals per sliding scale: if less than 80 = 0 units, 80-150 = 4 units, 150-200 = 6 units, 201-250 = 8 units, 251-300 = 10 units, 301-350 = 12 units, greater than 350 give 14 units and call PCP if persistent FSBS greater than 350. -There was an entry to check FSBS before meals and at bedtime. -There was an entry for Novolog 100/ml to be given per sliding scale order. -There were 43 opportunities with FSBS needing Novolog in March 2023. -There were 8 instances where Novolog was given but the amount of Novolog was not documented in the eMAR. Review of Resident #2's record revealed there were no notes documented related to the sliding scale insulin. Interview with the medication aide (MA) on 03/16/23 at 1:31 pm revealed: -She always put the amount of Novolog administered in a note on the computer. -There was no place on the eMAR to put the amount of Novolog that was administered so it had to be documented in a note. -She was trained by an agency nurse on the eMAR system when she was hired. -She did not know who audited the eMARs since the HWD resigned in December. -She did not know if cart audits were being completed. Interview with the MA on 03/17/23 at 11:40am revealed:	D 367		

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D 367	Continued From page 47 -She tried to be careful when giving Novolog to Resident #2 because he always received it before meals. -Resident #2 would not get Novolog before meals if his FSBS was less than 80 and she did not remember him ever having a FSBS less than 80. -There was no place on the eMAR to put the amount of Novolog that was given to Resident #2, and it had to be documented in a note. Interview with Resident #2 on 03/17/23 at 9:50am revealed: -He did not know his dose but knew he always had to get Novolog before his meals but not at bedtime. -He did not remember a time that he did not receive Novolog before meals. Telephone interview with the Regional Registered Nurse (RN) on 03/17/23 at 1:01pm revealed: -Since the HWD left, she had been working with the facility on the computers, eMARs, survey readiness, and whenever the facility needed help. -The nurses and MAs should be doing routine audits every shift on the eMARS and orders to make sure all medications were given and documented. -The eMAR had been corrected during our survey on 03/16/23 to calculate how much sliding scale insulin to be given and a place to put the amount of sliding scale insulin for Resident #2. Interview with the Administrator on 03/17/23 at 3:13pm revealed: -She was not aware the staff was not always documenting the amount of sliding scale insulin given to Resident #2. -The HWD was responsible for the auditing process, but she thought the Regional RN was doing the auditing since a previous HWD	D 367		

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resigned in December 2022.
-The Regional RN pulled the reports to make her aware of what was missing on the eMARs because there was no HWD currently in place.
-The MAs should be checking the orders each time medications were given.

Attempted telephone interview with Resident #2's PCP on 03/16/23 at 10:49am was unsuccessful.

Attempted telephone interview with Resident #2's Endocrinologist on 03/17/23 at 10:16am was unsuccessful.

2. Review of Resident #1's current FL2 dated 05/04/22 revealed:
-Diagnoses included unspecified insomnia, overactive bladder and unspecified dementia.
-An order for melatonin 3 mg (a medication for sleeplessness), 2 tablets at bedtime.

Interview with a MA on 03/15/23 at 3:45pm revealed:
-The MAs and HWD were able to enter medications on the eMAR, with a PCP's order.
-If an MA entered medication on the eMAR, the HWD was supposed to ensure the entry was accurate.
-Since the most recent HWD resigned in February 2023, the LPN was responsible for entering medication on the eMAR and ensuring the MAs entered accurate medication orders.
-She typically let the HWD or LPN enter medications on the eMAR, unless the medication had to be started immediately.
-She did not audit the eMAR.

Interview with the LPN on 03/15/23 at 4:22pm revealed:
-LPNs and MAs could add and discontinue

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CHARTER SENIOR LIVING OF CHARLOTTE	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 367	Continued From page 49 medications on the eMAR. -The pharmacy visited the facility quarterly and looked at the eMAR as well as the medications on the cart. -She did not check the eMARs to ensure MAs were accurately entering medication orders. Telephone interview with the Regional RN on 03/17/23 at 1:04pm revealed: -MAs, LPNs and HWDs could receive medication orders from providers. -Whoever received a medication order should send it to the facility's contracted pharmacy so the pharmacy could put the medication on the eMAR. -The contracted pharmacy could view and edit eMARs for all of the residents at the facility, even if the residents received their medication from a different pharmacy. -MAs were expected to compare the medication label with the order on the eMAR before administering each medication. -The LPNs should audit the eMARs daily to look for medications that were not administered. -She and other Regional RN completed weekly audits of the eMARs and looked at the orders that were uploaded into the facility's electronic record system. Interview with the Administrator on 03/17/23 at 2:53pm revealed: -All of the residents' medication orders should be sent to the facility's contracted pharmacy so the pharmacy could enter the orders onto the residents' eMARs. -The LPNs were able to enter orders on the eMAR if the medication needed to be administered immediately. -The HWD was responsible for verifying the orders the LPN entered on the eMAR. -Since the most recent HWD resigned in	D 367		

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D 367	Continued From page 50 February 2023, no one at the facility was auditing the eMARs against the medication orders. a. Review of Resident #1's record revealed there was not a signed PCP order for myrbetiq ER 25 mg (a medication used to treat overactive bladder), once daily. Review of Resident #1's January 2023, February 2023 and March 2023 eMARs revealed there was not an entry for myrbetiq ER 25 mg once daily. Observation of Resident #1's medications on hand on 03/15/23 at 12:42pm revealed: - Resident #1's medications were packaged in plastic pouches based on the date and what time they were scheduled to be administered. -The name, dose, quantity and order for each medication was printed on the corresponding pouch. -Myrbetiq ER 25 mg take one tablet daily was printed on the 8:00am medication pouch. -There was 1 tablet of myrbetiq ER 25 mg in an 8:00am medication pouch. Telephone interview with a Pharmacist at Resident #1's pharmacy on 03/15/23 at 3:54pm revealed the pharmacy had a signed order from Resident #1's PCP for myrbetiq ER 25 mg once daily dated 03/09/23. Interview with a MA on 03/15/23 at 3:45pm revealed: -Myrbetiq ER was not on Resident #1's March 2023 eMAR because it was discontinued on 11/02/22. -Resident #1's PCP sent electronic orders to the pharmacy for a lot of her medications and many times the facility did not receive a copy of the order.	D 367		

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D 367	Continued From page 51 -Since the myrbetiq was not administered on the shift that she worked, she was not aware Resident #1 had it on the medication cart. Interview with a second MA 03/17/23 at 11:40am revealed: -Resident #1 had taken myrbetiq ER in the past but she could not remember when. -Resident #1 did not use the facility's contracted pharmacy and her medication arrived packaged together based on what time of day it was due to be administered. -When she gave Resident #1 her morning medication, she opened the package in front of Resident #1 and gave her all the medications in the morning package. -She was trained to compare the medications listed on the eMAR and the medication labels before administering the medication. -She was not sure why she administered myrbetiq ER to Resident #1 when it was not on the eMAR. b. Review of Resident #1's signed PCP orders dated 11/30/22 revealed melatonin 3 mg, 2 tablets at bedtime. Review of Resident #1's January 2023, February 2023 and March 2023 eMARs revealed: -An entry dated 05/06/22 for melatonin 3 mg, 2 tablets at bedtime. -Melatonin 3 mg was documented as administered at 8:00pm from 01/01/23 to 03/13/23. Observation of Resident #1's medications on hand on 03/15/23 at 12:42pm revealed: -Resident #1's medications were packaged in plastic pouches based on the date and what time they were scheduled to be administered. -The name, dose, quantity and order for each	D 367		

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D 367	Continued From page 52 medication was printed on the corresponding pouch. -Melatonin 3 mg take one tablet at bedtime was printed on the 10:00pm medication pouch. -There was 1 tablet of melatonin 3 mg in a 10:00pm medication pouch. Telephone interview with a Pharmacist at Resident #1's pharmacy on 03/15/23 at 3:54pm revealed: -The pharmacy received a signed order from Resident #1's PCP on 03/09/23 for melatonin 3 mg, 1 tablet at bedtime. -The pharmacy did not have access to Resident #1's eMAR from the facility. Interview with a MA on 03/15/23 at 3:45pm revealed: -She knew Resident #1's melatonin dosage available for administration did not match the dosage on the eMAR and the last HWD contacted the pharmacy about it before she left in December 2022. -She was aware Resident #1's PCP electronically sent orders to the pharmacy and the pharmacy did not always send the order to the facility. -She forgot to call the pharmacy to follow up on Resident #1's melatonin.	D 367	1. Residents #1, #4 and #5 charts have been audited and corrected with updated PCP notes. 2. All resident clinical files have been audited to ensure they have all of the required documents for resident records along with updated PCP notes.	
D 433	10A NCAC 13F .1201(a) Resident Records 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 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	D 433	3. Education held on the protocol for filing all medical documentation for physician visits. HWD or designee will review all documentation upon return from a physician visit. HWD or designee will document any changes, update any orders and file the documentation in the residents charts. 4. HWD or designee will monitor daily during the week. HWD or designee will follow up on physician visits and make the proper doucmentation. POC completion date 5/12/23.	

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D 433	Continued From page 53 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 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 that were readily available for review for 3 of 5 sampled residents (Resident #1, 4, 5).	D 433		

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D 433	Continued From page 54 The findings are: 1. Review of Resident #1's current FL2 dated 05/04/22 revealed: -Diagnoses included unspecified dementia, Parkinson's disease and generalized muscle weakness. -An order for physician's visits every 90 days. Review of Resident #1's record revealed there were not any Primary Care Provider (PCP) visit notes. Telephone interview with a representative from Resident #1's PCP's office on 03/17/23 at 12:19pm revealed she was seen in the office on 02/08/23. Refer to interview with the Administrator on 03/17/23 2:53pm. 2. Review of Resident #4's current FL2 dated 01/17/23 revealed diagnoses included Parkinson's disease and dementia. Review of Resident #4's record revealed there were not any PCP visit notes. Interview with Resident #4's PCP on 03/14/23 at 12:28pm and telephone interview on 03/17/23 at 2:05pm revealed: -She saw Resident #4 on 03/07/23 and staff reported he was coughing during meals. -Her PCP visit notes were faxed to the facility by her office. Refer to interview with the Administrator on 03/17/23 at 2:53pm.	D 433		

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D 433	Continued From page 55 3. Review of Resident #5's current FL2 dated 03/17/22 revealed diagnoses included dementia and Alzheimer's Disease. Review of Resident #5's record revealed: -There was no documentation of PCP visit notes. -There was no documentation of a visit with the cardiologist. Telephone interview with Resident #5's PCP on 03/17/23 at 2:05pm revealed: -She saw the resident on 01/24/23 and his heart rate was low at 48 beats per minute (bpm). -She saw the resident on 01/31/23 because he started having symptoms of heart palpitations. -She saw the resident on 02/07/23 and his heart rate was irregular. -She saw the resident on 02/14/23 following his visit with the cardiologist on 02/13/23. -Her PCP visit notes were faxed to the facility by her office. Refer to interview with the Administrator on 03/17/23 2:53pm. _____ Interview with the Administrator on 03/17/23 at 2:53pm revealed: -She called the facility's contracted PCP's office multiple times between 03/14/23 and 03/17/23 to request copies of visit notes but they had not sent any. -Since there was not a HWD in the facility, the licensed practical nurse (LPN) was responsible for filing documents in the residents' records. -The HWD was responsible for auditing the residents' records and they have not been audited since the middle of February 2023.	D 433		

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D 459	Continued From page 56	D 459		
D 459	10A NCAC 13F .1302 Special Care Unit Disclosure 10A NCAC 13F .1302 Special Care Unit Disclosure (a) Only those facilities with units that meet the requirements of this Section may advertise, market or otherwise promote themselves as providing special care units for persons with Alzheimer's Disease or related disorders. (b) The facility shall disclose information about the special care unit according to G.S. 131D-8 and which addresses policies and procedures listed in Rule .1305 of this Section This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to disclose the form of care and treatment provided for residents in the special care unit (SCU) for 1 of 2 sampled residents (#5). The findings are: Review of Resident #5's current FL2 dated 03/17/22 revealed: -Diagnoses included Alzheimer's Disease, dementia, and delusions in Alzheimer's Disease. Review of Resident #5's Resident Register revealed an admission date of 04/01/22 to the SCU. Review of Resident #5's resident record revealed there was no SCU disclosure statement. Telephone interview with Resident #5's responsible party on 03/17/23 at 10:10am revealed she was unsure if she was provided with	D 459	1.Resident #5 chart has been audited and has a SCU agreement in the chart signed by the Responsible party. 2.MCD & HWD has audited all SCU resident files to ensure that each resident has a signed special care unit disclosure. 3.Prior to admission to the SCU the ED, AED, HWD, MCD or designee will ensure the SCU is signed and dated for all new admissions and transfers to the SCU. The MCD, HWD, or designee will monitor weekly for 4 weeks, then quarterly to ensure there is a SCU agreement. Backup SCU agreement documentation will be kept in the residents financial profile and uploaded to the residents digital chart. POC completion date is 5/12/23.	

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D 459	Continued From page 57 or signed a SCU disclosure statement when Resident #5 was admitted. Telephone interview with the Special Care Unit Coordinator (SCC) on 03/17/23 at 8:57am revealed: -The Administrator or the Assistant Administrator were responsible for ensuring the SCU disclosure was signed and the SCU policies were discussed with the residents' family member. -She was not aware Resident #5's SCU disclosure was not signed when he was admitted. Telephone interview with the Assistant Administrator on 03/17/23 at 1:50pm revealed the Administrator was responsible for ensuring the SCU disclosure was signed during the resident's admission. Interview with the Administrator on 03/17/23 at 3:13pm revealed: -She was responsible for ensuring the SCU disclosure was completed during the resident's admission. -She did an audit in June 2022 and Resident #5's SCU disclosure had been completed. -She was unable to locate Resident #5's SCU disclosure during the survey.	D 459		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall	D 464	1. Resident #4 and #5 have received updated special care unit profiles by the MCD. 2. All resident SCU profiles files have been audited and will be updated quarterly . The MCD, HWD, or designee will ensure all resident SCU profiles will be done within 30 days of admission and conducted quarterly per the regulations. 3. The MCD, HWD or designee will monitor weekly for 4 weeks and quarterly after. POC completion date 5/12/23.	

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D 464	Continued From page 58 develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 2 of 2 sampled residents (#4 and #5) had Special Care Unit (SCU) resident profiles updated on a quarterly basis (#4 and #5). The findings are: 1. Review of Resident #5's current FL2 dated 03/17/22 revealed: -Diagnoses included dementia and Alzheimer's Disease. -The recommended level of care was the SCU. Review of Resident #5's Resident Register revealed he was admitted to the facility on 04/01/22. Review of Resident #5's record revealed: -There was a SCU quarterly profile completed 07/26/22. -There was no additional documentation SCU quarterly profiles were completed after 07/26/22. Refer to telephone interview with the Special	D 464		

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D 464	Continued From page 59 Care Unit Coordinator (SCC) on 03/17/23 at 8:57am. Refer to telephone interview with the Regional Registered Nurse (RN) on 03/17/23 at 1:04pm. Refer to interview with the Administrator on 03/14/23 at 2:30pm. 2. Review of Resident #4's current FL2 dated 01/17/23 revealed: -Diagnoses included dementia and Parkinson's disease. -The recommended level of care was the SCU. Review of Resident #4's record on 03/14/23 revealed: -Resident #4 was admitted to the facility on 02/03/23. -Resident #4 did not have a completed SCU Resident Profile. Interview with the Administrator on 03/14/23 at 2:30pm revealed she saw Resident #4's care plan was completed upon admission by the HWD and was found in his electronic record but she did not know why the SCU profile was not completed at that time. Refer to telephone interview with the SCC on 03/17/23 at 8:57am. Refer to telephone interview with the Regional RN on 03/17/23 at 1:04pm. Refer to interview with the Administrator on 03/14/23 at 2:30pm. Telephone interview with the SCC on 03/17/23 at 8:57am revealed:	D 464		

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D 464	Continued From page 60 -The Health and Wellness Director (HWD) or licensed practical nurse (LPN) were responsible for completing the residents' SCU Resident Profile and SCU Quarterly Profile. -She was not aware Resident #4 and Resident #5 were missing the SCU Resident Profile but she knew the LPN had been thinning the residents' records over the last month. -She was not sure if anyone at the facility audited the residents' records. Telephone interview with the Regional RN on 03/17/23 at 1:04pm revealed she did not know who was responsible for ensuring the SCU Resident Profile was completed. Interview with Administrator on 03/14/23 at 2:30pm revealed: -The HWD was responsible for completing the SCU Resident Profile for new residents during the initial assessment when their SCU care plan was completed. -The facility had been without an HWD since mid-February 2023. -Since the HWD had stopped working in the facility in mid-February 2023, the regional office had been providing some assistance in completing SCU profiles.	D 464		